



THE
HEALTH
of
DEVON
in
1967

The Annual Report of the
County Medical Officer and
Principal School Medical Officer



COUNTY COUNCIL OF DEVON

ANNUAL REPORT

of the

COUNTY MEDICAL OFFICER

and the

PRINCIPAL SCHOOL MEDICAL OFFICER

FOR THE YEAR 1967

DEVON HEALTH COMMITTEE

as at 31st December, 1967

Health Committee

Chairman : †Rev. J. W. Timms.

Vice Chairman ; ‡Mrs. M. Owen.

Chairman of the Council (ex officio).

Vice-Chairman of the Council (ex officio).

Mr. Attenborough	Major Jackson	Mr. Pollard
Mr. Daymond	Mr. Jones	Mr. Prowse
Mr. Disney	Mr. Kerr	Mrs. Ratcliffe
Mr. Franks	Mr. Lee	Capt. G. H. Roberts
Mrs. Gibbens	Mrs. Park	Mr. Staddon
Sir G. C. Hayter- Hames	Mrs. Patt	Mr. Thomas
Rev. F. J. Hendy	§Mrs. Perkin	
||Mr. Hillard	Mrs. Penhale	

Nominated by the following bodies :

Community Council of Devon—Dr. A. Robinson Thomas.

Devon Branch, British Red Cross Society—Capt. G. T. Millet, C.B.E.

Devon Branch, St. John Ambulance Association—*Major T. W. Gracey.

Devon and Exeter Local Dental Association—Mr. G. Pendlebury.

Devon and Exeter Local Medical Committee—Dr. R. M. S. McConaghey,
Dr. G. C. C. MacVicker.

Devon and Exeter Pharmaceutical Committee—Mr. H. Jarvis Graves.

Executive Council for Devon and Exeter—Mr. A. D. J. Harvey.

Women's Royal Voluntary Service for Civil Defence—Mrs. R. Croft.

*Chairman of Ambulance, †Appointment and General Purposes, ‡Adult Health, ||Child Health and §Nursing sub-committees.

School Health Service Sub-Committee of the Education Committee

Chairman : Mrs. F. Hiley

Vice-Chairman : Mrs. A. S. Ratcliffe

Chairman and Vice-Chairman of the Council (ex officio)

*Chairman and Vice-Chairman of the Education Committee
(ex officio)*

Miss Hancock	Mr. Lee	Mr. Pridham
Mrs. Gibbens	Mrs. Owen	Mr. Vinnicombe
Rev. F. J. Hendy	Mrs. Perkin	Mrs. Penhale

STANDING SUB-COMMITTEES OF THE DEVON HEALTH COMMITTEE

Adult Health Sub-Committee: To exercise and carry out the powers and duties conferred or imposed on the County Council in respect of the following services:—

Mental health (other than for children) and the care and after-care of mentally disordered adults, including provision of adult training centres.

Registration of mental nursing homes.

Care and after-care of persons suffering from physical illness (including provision for tuberculosis, occupational therapy home teaching services and the chiropody service).

To visit, inspect and manage adult training centres and Barnstaple sheltered workshop including any hostel provided for such centres, and to deal with all matters connected therewith within the annual budget to be allocated by the Health Committee, provided that the Health Committee may, with the approval of the Finance Committee, modify such annual budget, as may be necessary from time to time in order to meet special items as they arise.

Ambulance Sub-Committee : To exercise and carry out the powers and duties conferred or imposed on the County Council in relation to the Ambulance Service.

Child Health Sub-Committee : To exercise and carry out the powers and duties conferred or imposed on the County Council in relation to the following services :

Care of young children.

Vaccination and immunisation.

Registration of day nurseries and child minders.

Care and training of mentally subnormal children of school age.

Registration of homes for mentally disordered in relation to homes for subnormal children.

To visit, inspect and manage junior training centres, including any hostel provided for such centres.

Nursing Sub-Committee : To exercise and carry out the powers and duties conferred or imposed on the County Council in relation to the following services:—

Care of mothers and infants.

Midwifery.

Health visiting.

Home nursing.

Domestic help.

Registration of nursing homes, except mental nursing homes.

Appointments and General Purposes Sub-Committee: To exercise and carry out the powers and duties conferred or imposed on the County Council in relation to the following:—

Staffing matters (including the appointment of staff not delegated to the County Medical Officer).

Provision of clinics and their maintenance.

Health Education.

Supply of Water.

Disposal of Sewage.

Food and Drugs.

Milk and Dairies.

Any other functions of the Health Committee not specifically referred to any other sub-committee.

Basildon Sub-Committee: To visit, inspect and manage the County Council's home for delicate children. To present annual reports of their stewardship and to report special items to the Health Committee.

Special ad hoc Health Centres Sub-Committee : To exercise and carry out the powers and duties conferred or imposed on the County Council in relation to the provision of Health Centres and their maintenance.

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INTRODUCTION

HEALTH DEPARTMENT,
County Hall,
Exeter.

July, 1968.

To: The Chairman, Aldermen and Members of the Devon County Council.

MR. CHAIRMAN, MY LORD, LADIES AND GENTLEMEN,

I have great pleasure in presenting my report for 1967.

The report contains details of the services provided by the health committee for the prevention of illness, promotion of health, and the care and after-care of persons in the community, and by the education committee in respect of the school health service.

The vital statistics continue to reveal several welcome facts—the most noteworthy being the continued fall in the perinatal mortality rate to the new record low of 18.6 per thousand births, compared with the rate of 25.4 per thousand for England and Wales. There has been a continued drop in these figures for the past five years, although boundary changes do not make the 1967 figure strictly comparable with those of the previous years.

For the sixth year in succession there were no cases of poliomyelitis and for the third year no cases of diphtheria. 1967 was an epidemic year for measles, with 5,498 notified cases. The next year in which we should normally expect an epidemic would be 1969 but it is to be hoped that sufficient vaccine will be available before then in order to protect the susceptible child population. Although measles is rarely a killer it can be a most unpleasant illness, with certain complications that add to the child's discomfort and may leave permanent disability. It is hoped that with the use of the vaccine, measles will join the ranks of smallpox, diphtheria and poliomyelitis, which are now so rarely seen. It is however vitally important for parents to realise that it is only by continuing to accept simple immunising procedures that such diseases can be kept in abeyance. I am not completely happy at the present level of immunity but look forward to the future when we can have computer facilities which, as other counties have shown, have provided the means of greatly improving the proportion of children who can be considered to be adequately protected.

During the year there were further achievements in the closer working relationships between general practitioners and various members of the health department's team. In particular I would mention health visitors, nurses and social workers in mental health, and the beneficial effects which have accrued have been even more marked where there are health centres.

A further three health centres were completed in the year and I should like to record my warm appreciation in this and other connections of the work of the chairman and secretary of the Executive Council, Dr. S. Noy Scott and Mr. Harry Bell, respectively, who have now both retired from office.

The country's present economic plight will have serious effects upon the department's work if a rapid improvement in the financial climate is not achieved. I would draw particular attention to my deputy's paper "Economics and the Health Service" which calls for a realistic approach to those many problems which have financial and humanitarian aspects and which sometimes cut across departmental and allied service boundaries. Since this was written it has been learned that the Minister of Health is sponsoring research at the University of Keele into "Special Housing for the Elderly and its Impact on the Need for Health and Welfare Services, especially as regards Residential Care".

The retirement clinics are continuing to reveal many diseases and problems that were previously unknown both in the medical and social fields.

The position regarding chiropody continues to give cause for concern. With mounting waiting lists and staffing problems some sessions have had to be terminated and the patients transferred to other clinics where improved facilities have allowed the work output of the individual chiropodist to rise.

One of the highlights of the year was the Dartmouth survey into the incidence of cancer of the uterine cervix and the breast. With the very active participation of all the doctors, together with health department staff, all the female population of the town aged between 25 and 60 were contacted and invited to attend the clinic for screening tests.

87 per cent of those eligible attended.

A full account of the survey is included in this report.

Throughout the county as a whole it is estimated that only 11.1 per cent of those eligible have attended for similar tests at local authority clinics since the scheme started but it is hoped to make further concentrated efforts elsewhere in the future.

I wish to thank members of the health committee for their continued and unwavering support which has enabled so much of value to be achieved, and to pay tribute to the devotion, loyalty and energy of the staff of the health department. I also wish to record my appreciation of the help and advice which has been unstintingly given by colleagues in other departments of the county council, by hospital personnel, general practitioners, voluntary workers and many others.

J. LYONS,
*County Medical Officer and
Principal School Medical Officer.*

STAFF OF THE HEALTH DEPARTMENT

County Medical Officer and Principal School Medical Officer		J. Lyons, M.B., Ch.B., M.R.C.S., L.R.C.P., D.P.H.
Deputy County Medical Officer and Deputy Principal School Medical Officer		D. S. Parken, M.B., B.S., M.R.C.S., L.R.C.P., D.C.H., D.P.H.
Senior Medical Officer for Maternal Health and Nursing		F. Gloria Richards M.R.C.S., L.R.C.P., D. (OBST.), R.C.O.G.
Senior Medical Officer for Child Health		D. O. McKnight, M.B., B.S., D.C.H., D.P.H.
Senior Medical Officer for Adult Health		J. A. Theobald, M.B., B.S., M.R.C.S., L.R.C.P., D.P.H.
Senior Assistant County Medical Officer		D. Cullen, M.B., B.S., L.R.C.P., M.R.C.S., D.P.H.
County Superintendent of Nursing and Supervisor of Midwives		Miss G. Heather, S.R.N., S.C.M., H.V.C.
Superintendent Health Visitor	..	Miss E. L. Hunter, S.R.N., C.M.B., (Pt. I), H.V.C.
Health Education Officer	.. ..	Miss P. O. Davies, R.M., D.H.ED.
County Health Inspector	.. ..	M. S. Powling, F.A.P.H.I., M.I.P.H.E.
Principal Administrative Officer	..	J. Cooke
Chief Clerk	.. ..	H. T. Baldwin
County Ambulance Officer	.. ..	R. P. Selley, D.P.A., F.I.A.O.
Home Help Organiser	.. ..	G. P. Brooks, D.P.A., D.S.A.
Principal Social Worker	.. ..	L. H. Jenkins, A.A.P.S.W., S.S.D.I.P. M.S.W.
Senior Occupational Therapist	..	Miss M. M. Keily, M.A.O.T.
Chief Chiropodist	.. ..	W. Beedle, M.Ch.S., R.M.A.
Senior Workshop Manager	.. ..	T. O. Hughes, D.M.A.
Administrative Officers:		
Maternal Health & Nursing Section		K. G. Baker
Adult Health Section	.. ..	R. H. G. Gibson (resigned 10.9.67) P. Brady (w.e.f. 5.11.67)
Child Health Section	.. ..	W. H. Nickels
General Health Section	.. ..	R. J. Hollett, D.P.A.

Medical Officers

L. G. Anderson, M.D., Ch.B., D.P.H.	} “mixed” appointments
M. E. Budding, B.Sc., M.B., Ch.B., D.P.H.	
S. C. Candler, M.B., Ch.B., M.R.C.S., L.R.C.P. (part-time)	
H. M. Davies, M.A., M.R.C.S., L.R.C.P., D.P.H.	
R. C. MacLeod, M.D., D.P.H., D.T.M. & H.	
D. K. MacTaggart, M.A., M.B., Ch.B., D.P.H. (Transferred Torquay Boro' w.e.f. 1.4.67)	
J. H. Wildman, M.R.C.S., L.R.C.P., D.P.H.	
E. Williams, M.R.C.S., L.R.C.P., D.P.H.	
J. Allott, M.B., Ch.B., D.P.H.	
N. E. R. Archer, M.A., D.M., B.Ch., D.P.H.	
W. E. Denbow, B.Sc., M.R.C.S., L.R.C.P., D.P.H.	
M. J. Dunn, M.B., Ch.B.	
L. Solomon, B.A., M.B., B.Ch., B.A.O., L.M., D.P.H., D.C.H. (resigned 31.12.67)	
P. W. Tait, M.B., Ch.B. (part-time) (resigned 31.12.67)	
W. Burgess, L.R.C.P., M.R.C.S., M.B., B.S., D.C.H., M.R.C.P., M.D. (part-time)	
E. A. Chalk, B.A., B.M., B.Ch. (part-time)	
J. M. MacTaggart, M.B., Ch.B., D.P.H. (part-time)	
E. A. Forsyth, M.B., D.P.H. (part-time)	
S. M. Gould, M.B., Ch.B. (part-time)	
J. M. Hall, M.B., B.S., D.P.H. (part-time)	
J. M. Shields, M.B., B.S., M.R.C.S., L.R.C.P., D.(OBST.), R.C.O.G. (part-time)	

School Ophthalmic Surgeons†

A. M. Barnett, M.A., M.R.C.S., L.R.C.P., D.O.
 R. C. Chaturvedi, M.B., B.S., D.O.
 A. J. A. McCormick, M.B., Ch.B., F.R.C.S., D.O.M.S.
 G. Searle, M.R.C.S., L.R.C.P., D.O.

Chest Physicians†

G. E. Adkins, M.B., B.Chir.
 W. E. B. Lloyd, M.R.C.S., L.R.C.P., D.P.H. (retired 13.7.67)
 B. R. Hillis, M.D., M.B., Ch.B., F.R.F.P.S., M.R.C.P. (Resigned 30.9.67)
 J. J. Y. Dawson, M.C., M.D., M.R.C.P.
 R. L. Midgley, M.R.C.S., M.R.C.P., M.B., B.S., M.D. (w.e.f. 14.7.67)
 J. T. Smyth, M.R.C.S., M.R.C.P., M.B., B.S. (w.e.f. 1.10.67)

Psychiatrists, Child Guidance†

H. S. Gaussen, M.R.C.S., L.R.C.P.
 C. J. Wardle, M.D., B.S., M.R.C.S., L.R.C.P., D.P.M.
 P. M. Jackson, M.B., B.Ch., D.P.M. (w.e.f. 1.10.67)

†On staff of the Regional Hospital Board.

DENTAL SERVICE

Chief County Dental Officer and
Principal School Dental Officer .. J. D. Sykes, L.D.S. (deceased 26.6.67)
F. H. Stewart, B.D.S. (w.e.f. 1.1.68)
County Orthodontist J. D. W. Barnett, B.D.S., D.ORTH.

Dental Officers (full-time) :

G. W. B. Bateman, L.D.S., R.C.S.
Kathleen Billings, B.D.S.
G. J. Derbyshire, L.D.S.
J. L. Dickson, L.D.S., R.F.P.S.
A. R. Gammack, L.D.S., R.C.S. (w.e.f. 1.4.67)
H. W. Gibbs, L.D.S., R.C.S.
H. G. Hobdell, L.D.S., R.C.S.
J. F. Hunt, L.D.S., R.C.S.
F. A. Pearse, O.B.E., L.D.S., R.C.S. (Transferred to Plymouth 1.4.67)
C. T. Pomeroy, L.D.S., R.C.S.
A. Shipley, B.D.S.
K. P. Smith, L.D.S., R.C.S.
J. W. Steer, L.D.S., R.C.S.
Valerie E. Street, B.D.S. (w.e.f. 1.6.67)
C. N. van Rijswijk, B.Ch.D.
J. K. Vowles, B.D.S.
F. M. Warren, B.D.S., L.D.S., R.C.S.
H. D. Williams, L.D.S., R.C.S.

Dental Auxiliaries :

Miss D. R. Williams (resigned 29.4.67)
Mrs. R. Martin (part-time w. e.f. 1.9.67)

Dental Hygienist :

Miss P. H. Turnage

PART I

VITAL STATISTICS

Area and Population

Births

Deaths

VITAL STATISTICS

Devon is a predominantly rural county but has a concentration of almost 100,000 in the Torbay area, where almost one-fifth of the population reside. The remainder of the county, apart from relatively small urban areas, consists of rural districts which include two large areas of sparsely populated countryside, Dartmoor and the western part of Exmoor.

A large part of the rural district of Plympton St. Mary, including the most heavily populated areas, was transferred to Plymouth City Council on 1st April, 1967, with an approximate population of 33,570. The Municipal Borough of South Molton was incorporated with the South Molton Rural District Council on the same date.

Area and Population

	<i>Municipal Boroughs and Urban Districts</i>	<i>Rural Districts</i>	<i>Administrative County</i>
Area (acres)	121,105	1,505,324	1,626,429
Population (estimated mid-1967)	282,350	247,540	529,890

Number of Municipal Boroughs, 9 ; Urban Districts, 18 ; Rural Districts, 16 ; Total, 43.

Statistics are detailed on pages 24 and 46, but the following is both a summary and an outline of the more interesting facts.

Births

Registered live births number 7,419, equivalent to a rate of 17.3 per thousand population. The number of stillbirths registered was 96 corresponding to a rate of 12.77 per thousand total births.

Deaths

The total number of deaths allocated to the administrative county was 7,751 compared with 8,481 in 1966.

Due to the age/sex distribution of the population differing from area to area throughout the county, crude rates although based on actual occurrences fail to provide a useful mortality index. To enable more realistic comparisons of the mortality between different areas to be made, compensating factors are applied to the crude rates. The death rates from all causes for the past six years, adjusted by the appropriate factors, for the aggregates of boroughs and urban districts, rural districts and the administrative county, also the rates for England and Wales, are given below :

Year	Municipal Boroughs and Urban Districts	Rural Districts	Administrative County	England and Wales
1962	12.1	11.3	11.7	11.9
1963	11.6	11.5	11.7	12.2
1964	10.9	10.1	10.4	11.3
1965	10.3	10.2	10.2	11.5
1966	10.7	10.4	10.6	11.7
1967	9.7	9.9	9.8	11.2

PERINATAL MORTALITY

This term is used to describe stillbirths, together with deaths during the first week of life, and the resultant rate expressed per thousand total births. The 1967 rate of 18.63 is a reduction of 2.39 on the 1966 rate.

INFANT MORTALITY

Deaths of infants in the first year of life numbered 80 representing a rate of 11.32 per thousand live births. This figure is much lower than 1966 when the rate per thousand live births was 17.73, and the total number of infant deaths in the first year of life was 145.

CAUSES OF DEATH

	1967	1966
Diseases of heart and circulatory system	3,157	3,413
Cancer and other malignant diseases	1,487	1,575
Vascular lesions of nervous system	1,264	1,311
Diseases of respiratory system (excluding tuberculosis)	653	877
Accidents, suicides, etc.	296	298
Diseases of stomach and digestive system	81	88
Diseases of genito-urinary system	69	75
Tuberculosis	22	24
Other infectious diseases	17	30
Maternal deaths	—	3
All other causes	705	787
Total deaths	7,751	8,481

PRINCIPAL CAUSES OF DEATH

The main causes of death remained, in descending order, as in recent years .

The relative contributions of the diseases, which accounted for 88.19% of the total mortality, is indicated below.

PERCENTAGE CONTRIBUTION OF TOTAL CAUSES

Main Causes	1962	1963	1964	1965	1966	1967
Malignant Neoplasms	17.97	17.06	18.98	18.53	18.51	19.04
Vascular Lesions of Nervous System	16.53	16.09	16.08	15.94	15.45	16.31
Heart and Circulatory Diseases	40.32	39.57	39.34	41.63	40.25	40.60
Disease of Respiratory System	9.28	11.60	9.75	8.42	10.34	8.42
Accidents, Suicide and Violence	4.02	3.96	3.68	3.51	3.51	3.82

CAUSES OF DEATH AT DIFFERENT PERIODS OF LIFE IN THE ADMINISTRATIVE COUNTY OF DEVON 1967

Causes of Death	Sex	All ages	Under 4 weeks	4 weeks and under 1 year	1—	5—	15—	25—	35—	45—	55—	65—	75—
1. Tuberculosis—respiratory	M	13	—	—	—	—	—	—	—	1	1	6	5
	F	7	—	—	—	1	—	—	1	2	1	—	2
2. Tuberculosis—other	M	—	—	—	—	—	—	—	—	—	—	—	—
	F	2	—	—	—	—	—	—	—	—	—	—	—
3. Syphilitic disease	M	3	—	—	—	—	—	—	—	—	2	1	2
	F	4	—	—	—	—	—	—	—	—	1	1	—
4. Diphtheria	M	—	—	—	—	—	—	—	—	—	—	—	—
	F	—	—	—	—	—	—	—	—	—	—	—	—
5. Whooping cough	M	—	—	—	—	—	—	—	—	—	—	—	—
	F	—	—	—	—	—	—	—	—	—	—	—	—
6. Meningococcal infections	M	1	—	—	—	—	—	—	—	—	1	—	—
	F	—	—	—	—	—	—	—	—	—	—	—	—
7. Acute poliomyelitis	M	—	—	—	—	—	—	—	—	—	—	—	—
	F	—	—	—	—	—	—	—	—	—	—	—	—
8. Measles	M	—	—	—	—	—	—	—	—	—	—	—	—
	F	—	—	—	—	—	—	—	—	—	—	—	—
9. Other infective and parasitic diseases	M	5	—	—	—	—	—	—	1	—	1	—	3
	F	4	—	—	1	—	—	—	1	—	—	1	1
10. Malignant neoplasm, stomach	M	94	—	—	—	—	—	—	—	3	19	36	35
	F	75	—	—	—	—	—	—	1	3	12	15	43
11. Malignant neoplasm, lung, bronchus	M	261	—	—	—	—	—	—	2	28	66	123	42
	F	71	—	—	—	—	—	—	1	6	19	24	21
12. Malignant neoplasm, breast	M	2	—	—	—	—	—	—	—	—	1	1	—
	F	144	—	—	—	—	—	1	2	21	37	39	44
13. Malignant neoplasm, uterus	M	—	—	—	—	—	—	—	—	—	—	—	—
	F	45	—	—	—	—	—	—	2	10	7	11	15
14. Other malignant and lymphatic neoplasm	M	382	—	—	—	4	—	5	10	23	80	129	130
	F	363	—	1	3	1	—	2	5	22	78	113	137
15. Leukaemia, aleukaemia	M	25	—	—	—	—	—	—	2	1	3	10	7
	F	25	—	—	1	—	—	1	2	1	10	3	6
16. Diabetes	M	19	—	—	—	—	—	—	—	1	2	10	6
	F	40	—	—	—	1	—	—	1	—	6	12	20
17. Vascular lesions of nervous system	M	494	—	—	—	—	—	—	2	15	47	150	278
	F	770	—	—	—	—	—	1	2	17	52	161	537

TUBERCULOSIS

DEATHS FROM TUBERCULOSIS

Classification	Age Groups																Total		Grand Total
	0—		1—		5—		15—		25—		45—		65—		75—				
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
Respiratory	—	—	—	—	—	—	—	1	—	1	2	3	6	—	5	2	13	7	20
Non-Respiratory	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2	—	2	2
Totals	—	—	—	—	—	—	—	1	—	1	2	3	6	—	5	4	13	9	22

The deaths in this group were two less than in the preceeding year. It is imperative that all preventive measures shall continue to be applied diligently, with the ultimate goal of complete eradication. It should be noted that 70% of deaths occurred in persons over 65, most of whom had tuberculosis for some years.

INFECTIVE AND PARASITIC DISEASES (excluding tuberculosis)

There were 17 deaths in this group compared with 30 last year, and once again diphtheria and poliomyelitis are conspicuous by their absence. This is due mainly to the acceptance of immunisation by large numbers of the population.

CANCER

The total, including leukaemia, numbered 1,487 a lower figure than last year. Lung cancer deaths remain a particular cause of concern, since all the available evidence points indisputably to cigarette smoking as the most important single factor in the causation of this disease.

The following table shows the relative contributions to mortality from the separately classified sites.

CANCER DEATHS

Year	Stomach	Lung, Bronchus	Breast	Uterus	Other Malignant and Lymphatic Neoplasms	Leukaemia, Aleukaemia	Total all sites
1962 M.	103	205	1	—	383	28	720
1962 F.	85	53	139	59	353	20	709
T.	188	258	140	59	736	48	1,429
1963 M.	94	241	—	—	411	25	771
1963 F.	79	51	137	45	341	17	670
T.	173	292	137	45	752	42	1,441
1964 M.	102	228	1	—	389	22	742
1964 F.	89	60	134	75	373	26	757
T.	191	288	135	75	762	48	1,499
1965 M.	109	247	1	—	428	15	800
1965 F.	70	55	144	54	377	20	720
T.	179	302	145	54	805	35	1,520
1966 M.	110	275	2	—	426	21	834
1966 F.	53	59	145	69	395	20	741
T.	163	334	147	69	821	41	1,575
1967 M.	94	261	2	—	382	25	764
1967 F.	75	71	144	45	363	25	723
T.	169	332	146	45	745	50	1,487

VASCULAR LESIONS OF THE NERVOUS SYSTEM

Assigned to this group were 1,264 deaths.

HEART AND CIRCULATORY DISEASES

Causing 3,157 deaths, this group carries year by year the highest mortality and accounts for approximately 40.60% of the total causes.

HEART AND OTHER CIRCULATORY DISEASE DEATHS

Year	Coronary disease, angina		Hypertension with heart disease		Other heart disease		Other circulatory disease		Total	
	No. of Deaths	Death Rate	No. of Deaths	Death Rate	No. of Deaths	Death Rate	No. of Deaths	Death Rate	No. of Deaths	Death Rate
1962	1,392	2.05	157	0.23	1,279	1.88	379	0.56	3,207	4.72
1963	1,569	2.17	180	0.25	1,254	1.73	339	0.47	3,342	4.61
1964	1,477	1.94	137	0.18	1,161	1.52	332	0.44	3,107	4.08
1965	1,670	1.83	135	0.17	1,201	1.49	408	0.50	3,414	4.24
1966	1,777	2.22	125	0.22	1,121	1.40	390	0.49	3,413	4.26
1967	1,672	2.11	130	0.16	914	1.16	441	0.56	3,157	3.99

DEATHS FROM ACCIDENTS, VIOLENT CAUSES, ETC.

The total number of deaths over the past six years has tended to fluctuate but although the total for this year is slightly lower, it must not be forgotten that a large part of the most heavily populated areas of Plympton St. Mary were transferred to Plymouth City Council on 1st April, 1967. Notwithstanding this it should be noted that there was substantial increase in the number of deaths from suicide.

Year	Motor Vehicle Accidents	All other Accidents	Suicide	Homicide and Operations of War	Total Accidents, Suicide, Homicide
1962	56	175	79	10	320
1963	63	193	75	3	334
1964	70	141	75	5	291
1965	84	142	59	3	288
1966	66	163	65	4	298
1967	64	151	75	6	296

DISEASES OF THE RESPIRATORY SYSTEM (excluding Tuberculosis and Lung Cancer)

The 653 deaths assigned to this group included those due to bronchitis, pneumonia, and influenza, and involved chiefly the older age groups.

The national death-rate in what is widely known as the "English disease" remains among the highest in Europe. Much could be done to effect control, as smoking and air pollution are contributory factors.

Suicides

	Totals	15-24	25-34	35-44	45-54	55-64	65-74	75 Plus	Incidence rate (Per 1,000 pop.)
Rural districts M	17	2	1	1	4	4	3	2	0.125
F	15	—	1	4	2	3	4	1	
(pop. 255,850) Total	32	2	2	5	6	7	7	3	
Urban districts M	25	—	1	7	7	3	5	2	0.152
F	18	—	1	3	4	6	4	—	
(Pop. 282,350) Total	43	—	2	10	11	9	9	2	
Admin. County Rural & urban districts M	42	2	2	8	11	7	8	4	0.139
F Pop. 538,200	33	—	2	7	6	9	8	1	
Total	75	2	4	15	17	16	16	5	0.139

As there has been a change of boundary during the year when part of the rural district of Plympton St. Mary was transferred to Plymouth City Council, the statistics represent the events assigned to the area within boundaries as they existed at the registration of each event. To allow calculation of valid Birth and Death rates, the figures shown under "Estimated Mid-Year Population"

is a weighted average of the mid-year population of the area as constituted before and after the change. This population figure is calculated only for the purpose described above and will not agree with the official population figure published in the Registrar General's "Annual Estimates of the Population of England and Wales and of Local Authority Areas, 1967'."

STATISTICS—COUNTY OF DEVON 1967

Districts	Populations (Estim'd) Home	Estimates of Population Aged 65 Years and over	Births			Infant Deaths		Tuberculous and Other Infectious Diseases	Cancer & Other Malignant Diseases	Vascular Lesions of Nervous System	Heart and Circulatory System	Respiratory (ex- cluding Tubercu- losis)	Stomach & Digestive System	Genito- Urinary	Maternal	All Others	Accident, Suicide, etc.	Total Deaths		
			Rates per 1,000 Population		Under 4 weeks	Under 1 year												No.	Crude Rate	Cor'd Rate
			No.	Crude Rate		No.	No.													
Budleigh Salterton Exmouth St. Thomas	3,830 22,420 30,130	1,310 5,250 4,490	27 335 406	7.0 14.9 13.5	12.6 21.6 14.7	— 2 4	1 2 4	1 2 3	20 74 67	17 70 50	35 157 167	8 23 63	1 6 6	— 3 3	— — —	4 37 32	5 8 18	91 380 409	23.759 16.949 13.575	10.929 8.475 8.823
Ottery St. Mary Sidmouth Honiton Seaton Axminster Honiton	5,100 11,750 5,260 3,740 14,850 7,260	840 3,680 690 1,110 2,980 1,180	77 113 80 31 164 107	15.1 9.6 15.2 8.3 11.0 14.7	22.5 18.2 16.4 13.6 14.4 17.2	— 1 1 2 3 —	— 1 1 1 2 —	— — 1 — — —	8 68 9 14 41 11	7 38 23 12 17 8	24 96 28 24 79 37	5 20 1 7 16 7	— 3 2 1 1 1	— — — — — —	4 19 5 9 17 4	— 9 1 1 15 5	48 254 71 69 188 74	9.412 21.617 13.498 18.449 12.660 10.193	5.741 9.295 6.479 7.933 9.875 9.479	
Credton Credton Tiverton Tiverton	4,880 9,870 14,370 20,840	770 1,580 1,910 3,610	68 139 203 289	13.9 14.1 14.1 13.9	14.7 15.8 14.9 15.7	— 2 6 —	— 1 4 —	— 1 2 —	13 18 22 41	6 13 35 41	20 40 55 103	15 8 13 32	— 2 — 4	— 1 2 3	— — — —	8 9 13 16	63 98 149 247	12.910 9.929 10.369 11.852	11.750 9.234 8.710 10.193	
Barnstaple Barnstaple **South Molton Ilfracombe Torrington Northam Bideford Holsworthy Great Torrington Bideford Lynton	16,340 27,980 11,350 8,240 7,500 7,450 10,850 8,330 2,920 5,080 1,680	2,600 4,750 1,920 1,860 1,190 1,450 1,840 1,040 560 790 310	323 432 162 113 90 91 191 115 50 94 30	19.8 15.4 14.3 13.7 12.3 17.6 16.9 13.8 17.1 18.5 17.9	20.8 18.8 17.0 17.5 14.6 17.8 19.9 16.0 20.3 21.5 20.4	3 8 10 11 2 4 — 1 — 2 —	3 6 6 7 2 2 — 1 — — —	1 1 1 1 — 1 1 — 1 — —	34 73 31 26 14 20 33 19 12 20 6	28 54 17 30 16 18 31 17 6 6	80 129 66 72 28 51 73 31 16 25 9	19 22 12 8 5 17 4 2 1 2	— 2 — 2 2 1 — — — —	1 2 3 1 — 1 3 2 2 —	21 28 27 9 13 13 15 23 7 9 5	10 14 5 8 4 6 5 2 1 2 2	194 325 162 157 82 111 177 99 47 66 30	11.873 11.615 14.273 19.053 11.233 14.900 16.313 11.885 16.096 12.992 17.857	8.905 9.527 11.133 12.766 10.334 8.939 12.561 9.627 9.818 12.472 10.357	
Okehampton Okehampton	3,810 11,340	750 2,280	48 153	12.6 13.5	14.2 17.3	2 —	1 1	1 2	10 27	11 18	27 68	5 21	2 2	1 —	— —	5 10	2 7	64 155	16.798 13.668	11.255 10.935

STATISTICS—COUNTY OF DEVON 1967

Districts	Populations (Estim'd) Home	Estimates of Population Aged 65 Years and over	Births			Infant Deaths		Tuberculosis and Other Infectious Diseases	Cancer & Other Malignant Diseases	Vascular Lesions of Nervous System	Heart and Circulatory System	Respiratory (ex- cluding Tubercu- culosis)	Stomach & Digestive System	Genito- Urinary	Maternal	All Others	Accident, Suicide, etc.	Total Deaths		
			No.	Rates per 1,000 Population		Under 4 weeks	Under 1 year											No.	Crude Rate	Cor'd Rate
				Crude Rate	Cor'd Rate															
Salcombe Kingsbridge Kingsbridge *Plymouth St. Mary Tavistock Totnes Totnes M.B. U.D.	2,420	550	25	10.3	13.7	—	—	—	5	5	11	5	—	1	—	6	—	33	13.636	8.182
	3,320	570	34	10.2	11.9	—	1	—	15	7	18	6	2	—	—	2	—	50	15.060	13.404
	11,900	2,130	139	11.7	14.3	2	—	—	27	20	67	8	2	—	—	17	3	146	12.269	9.570
	22,770	2,960	370	16.2	16.7	—	2	—	45	49	106	27	4	6	—	18	7	264	11.594	9.275
	22,600	3,780	318	14.1	16.9	—	1	—	51	54	110	27	6	—	—	35	16	300	13.274	11.150
	15,990	2,870	191	11.9	15.1	—	—	—	37	49	92	27	1	2	—	21	12	243	15.197	9.118
	5,630	1,050	78	13.9	16.5	—	—	—	18	10	31	8	2	—	—	20	4	93	16.519	9.581
	2,530	510	32	12.6	16.8	—	—	—	7	9	19	3	2	—	—	4	1	46	18.182	13.455
Ashburton Dawlish Teignmouth Newton Abbot Newton Abbot R.D.	3,050	570	49	16.1	20.5	—	1	—	11	9	17	3	—	—	—	10	1	51	16.721	10.033
	7,830	1,620	81	11.4	12.9	2	1	—	27	16	51	18	2	—	—	5	4	123	15.709	10.999
	12,130	3,010	153	12.6	19.5	2	3	—	38	47	91	25	—	—	—	21	9	231	19.044	9.903
	18,630	3,450	276	14.8	16.4	4	3	3	71	62	120	25	3	3	—	33	9	329	17.660	11.126
	28,260	5,780	408	14.4	17.3	2	3	1	90	63	158	26	5	4	—	23	15	385	13.623	9.945
Torquay	52,300	11,850	701	13.4	17.0	10	9	8	153	142	358	53	7	9	—	60	34	824	15.755	10.398
Dartmouth Brixham Paignton	7,190	1,120	82	11.4	12.9	4	3	—	18	16	35	9	1	2	—	5	8	94	13.074	12.158
	12,830	2,310	194	15.1	21.3	2	2	1	43	22	87	15	2	1	—	19	5	195	15.199	8.815
	31,850	7,940	357	11.2	16.5	5	3	2	100	89	246	30	3	3	—	44	17	534	16.766	9.054
Administrative County	538,200	102,810	7419	13.8	17.3	98	84	39	1487	1264	3157	653	81	69	—	705	296	7751	14.402	9.793

*As there has been a change of boundary during the year when part of the rural district of Plympton St. Mary was transferred to Plymouth City Council, the statistics represent the events assigned to the area within boundaries as they existed at the registration of each event. To allow calculation of valid Birth and Death rates, the figure shown under "Estimated Mid-Year Population" is a weighted average of the mid-year population of the area as constituted before and after the change. This population figure is calculated only for the purpose described above and will not agree with the official population figure published in the Registrar General's "Annual Estimates of the Population of England and Wales and of Local Authority Areas, 1967".

**The figures shown include events registered during the period 1st July to 31st March, 1967, for the component parts of the changed areas.

PART II
DISTRICT MEDICAL OFFICERS OF HEALTH

DISTRICT MEDICAL OFFICERS OF HEALTH

Area	District Councils		District Medical Officers of Health
1	Exmouth	U.D.	L. G. Anderson, M.D., D.P.H. ("mixed" appointment)
	Budleigh S'ton	U.D.	
	St Thomas	R.D.	
2	Ottery St. Mary	U.D.	R. C. MacLeod, M.D., D.P.H., D.T.M. & H. ("mixed" appointment)
	Sidmouth	U.D.	
	Honiton	M.B.	
	Seaton	U.D.	
	Axminster	R.D.	
	Honiton	R.D.	
3	Crediton	U.D.	N. F. Sawers, M.B., Ch.B.
	Crediton	R.D.	L. N. Jackson, B.A., D.M.
	Tiverton	M.B.	G. Nicholson, M.D., D.P.H., F.R.C.S. (combined appointment)
	Tiverton	R.D.	
4	Barnstaple	M.B.	E. Williams, .. Stella C. Candler, M.B., M.R.C.S., L.R.C.P., .. Ch.B., M.R.C.S., L.R.C.P. D.P.H. ("mixed" .. Deputy Medical appointment) .. Officer of Health
	Barnstaple	R.D.	
	South Molton	R.D.	
	Ilfracombe	U.D.	
	Torrington	R.D.	
	Northam	U.D.	
	Bideford	M.B.	
	Holsworthy	R.D.	
	Great Torrington	M.B.	C. F. R. Briggs, M.B., B.S., M.R.C.S., L.R.C.P.
	Bideford	R.D.	N. B. Betts, M.B., B.Chir., F.R.C.S., L.R.C.P.
	Lynton	U.D.	M. P. Nightingale, M.R.C.S., L.R.C.P.
5	Salcombe	U.D.	J. H. Wildman, .. Mary E. Budding, B.Sc. M.R.C.S., L.R.C.P., .. M.B., B.Ch., D.P.H., D.P.H. .. Deputy Medical (commenced .. Officer of Health. 17.7.67) ("mixed" appointment)
	Kingsbridge	U.D.	
	Kingsbridge	R.D.	
	Plympton St. M.	R.D.	
	Tavistock	R.D.	
	Totnes	M.B.	
	Totnes	R.D.	
	Buckfastleigh	U.D.	
	Dartmouth	M.B.	
	(from 17.7.67)		
6	Ashburton	U.D.	H. M. Davies, M.A., M.R.C.S., L.R.C.P., D.P.H., ("mixed" appointment)
	Dawlish	U.D.	
	Teignmouth	U.D.	
	Newton Abbot	U.D.	
	Newton Abbot	R.D.	
7	Torquay	M.B.	D. K. MacTaggart, M.A., M.B., Ch.B., D.P.H.
8	Dartmouth	M.B.	J. H. Wildman, M.R.C.S., L.R.C.P., D.P.H., ("mixed" appointment) (Resigned 16.7.67)
	Brixham	U.D.	
	Paignton	U.D.	
9	Okehampton	M.B.	Mary E. Budding, B.Sc., M.B., B.Ch., D.P.H. ("mixed" appointment)
	Okehampton	R.D.	

DISTRICT MEDICAL OFFICERS OF HEALTH

The Ministry of Health confirmed during the year the county council scheme for the revision of the areas of district medical officers of health under Section 111 of the Local Government Act 1933. In the new No. 5 area Dr. Wildman took up his appointment as medical officer of health from the 17th July 1967. Dartmouth Borough elected to join the No. 5 area from this date. The medical officer of health responsibilities for the urban districts of Paignton and Brixham were undertaken by Dr. D. K. MacTaggart from the date of Dr. Wildman's resignation. Those district medical officers of health holding "mixed" appointments spend a proportion of their time, varying from 85-80%, undertaking public health duties with the district councils, the remaining proportion of their time being spent on duties for the county council and these are mainly connected with the school health and child welfare services.

In one area a "combined" appointment was established some years ago. In this type of appointment the medical officer is responsible solely for the work of his district councils. The medical officer of health for this area has always taken a considerable interest in the work of the health department and has been most helpful in arranging meetings in his area when items of joint interest have to be discussed.

The medical officers of health for five district councils are also general practitioners in their areas. In two of these areas (Great Torrington and Lynton) the general practitioners are now functioning from health centres.

South Molton Borough and South Molton Rural District Councils amalgamated on the 1st April 1967.

PART III
EPIDEMIOLOGY
Notification of Infections Disease
Vaccination and Immunisation
TUBERCULOSIS

EPIDEMIOLOGY

Incidence and Notification of Infectious Disease

This table affords a comparison with the preceding five years:

	<i>Number of corrected notifications</i>					
	1962	1963	1964	1965	1966	1967
Measles	2,664	6,085	2,679	5,863	2,700	5,498
Whooping Cough ..	68	197	322	89	175	133
Diphtheria	—	—	1	—	—	—
Poliomyelitis ..	—	—	—	—	—	—
Scarlet Fever ..	99	152	142	145	140	131
Erysipelas	22	19	24	25	14	11
Pneumonia	127	178	121	81	129	90
Meningitis	1	6	8	4	3	7
Tuberculosis ..	156	117	110	131	122	73
Typhoid or paratyphoid	2	1	3	—	—	2
Dysentery	419	167	70	52	109	174
Food Poisoning ..	19	36	87	26	48	6
Ophthalmia Neonatorum	3	1	2	—	8	—
Puerperal Pyrexia ..	11	7	10	8	6	—

For the sixth year in succession, no cases of poliomyelitis were notified in Devon and this is considered to be mainly due to the successful vaccination campaign.

There was no notification of diphtheria this year.

There were more cases of dysentery this year, and this together with the 6 cases of food poisoning shows an obvious need for more personal hygiene education, particularly of those handling food.

Veneral Diseases

	<i>New Cases Treated</i>					
	1962	1963	1964	1965	1966	1967
Syphilis	6	4	18	14	15	12
Gonorrhoea	49	50	106	102	104	164
Other conditions ..	300	306	279	374	447	512

Veneral diseases are not notifiable and the figures shown above are only in respect of cases treated at the special centres. It is obvious that these figures are an unknown fraction of the total cases of veneral disease occurring in the area.

Vaccination and Immunisation

DIPHTHERIA, WHOOPING COUGH AND TETANUS (Combined Immunisation)

The use of combined prophylactics involves fewer injections and is thus more acceptable to parents and infants, and there is a greater probability of a course being completed. Three injections are recommended; the first after two months but before six months, and the second a month afterwards and the third a month after the second dose. A booster dose is offered at approximately eighteen months. Supplies of the vaccine can be obtained by doctors from the county health department together with the necessary record cards. Supplies of separate diphtheria, whooping cough or tetanus prophylactics are also available should these be required.

Diphtheria Immunisation (including combined immunisation)

The numbers of children who received immunisation since 1948 are shown in the following table. In 1965 the Ministry of Health revised the age groupings, hence the changed setting of the table as from that year.

Year	No. of children who completed a full course of immunisation			No. of children who were given a reinforcing injection
	Under 5	5-14	Total	
1948	2,379	209	2,388	1,030
1949	5,787	1,015	6,802	9,133
1950	4,460	572	5,032	5,288
1951	5,206	582	5,788	7,345
1952	4,838	574	5,412	8,798
1953	4,554	833	5,387	9,243
1954	4,865	959	5,824	8,329
1955	4,535	844	5,379	8,602
1956	4,914	690	5,604	7,564
1957	4,590	694	5,284	6,144
1958	4,058	473	4,531	4,048
1959	6,490	646	7,136	3,839
1960	5,799	561	6,360	4,247
1961	5,782	824	6,606	3,708
1962	6,394	1,107	7,501	3,866
1963	6,847	946	6,693	4,197
1964	6,857	703	7,560	6,883

	Under 1	1-	2-	3-	4-7	Others under age 16	Totals	Booster
1965	2810	3085	522	206	509	310	7442	7,500
1966	2975	3159	390	152	498	599	7773	9,244
1967	3558	2981	409	129	461	276	7814	9,274

Whooping Cough (including combined immunisation)

The number of children protected against whooping cough during 1967 is as follows:

	Year of Birth					Others under age 16	Total	Booster
	1967	1966	1965	1964	1960-63			
A.C.M.O's.	1496	188	70	17	32	2	1805	1203
G.P's.	2039	2768	328	106	162	39	5442	2941
Total	3535	2956	398	123	194	41	7247	4144

Tetanus

Older children who did not have the appportunity to receive tetanus immunisation in infancy, have in some areas been offered a full course of 3 injections. This involves a great deal of extra work for the medical officers concerned, but is very worth while.

Tetanus (including combined immunisation)

	Year of birth					Other under age 16	Total	Booster
	1967	1966	1965	1964	1960-63			
A.C.M.O's.	1514	191	72	20	279	707	2783	4978
G.P's. ..	2047	2800	346	121	215	638	6167	4891
Total ..	3561	2991	418	141	494	1345	8950	9869

Poliomyelitis

Vaccination against poliomyelitis is now offered to all persons who have not at the time of their application for vaccination reached the age of forty and also to special groups of personnel and their families who may come into contact with poliomyelitis cases. Oral vaccine is used but salk vaccine can be made available if required, though it will be noted that no salk vaccine was used in 1967. Persons going to visit or reside in a country outside Europe other than Canada or the United States of America may also receive vaccination against polio.

In the autumn of 1965 the Ministry of Health gave permission for routine poliomyelitis vaccine to be administered at the same time as the "triple" immunisation and most medical officers have taken advantage of this. It reduces the number of the visits of the child to the clinic for these procedures by 3, and mothers much appreciate this. However, it means that the polio vaccination is commenced at an earlier age than before and the baby's response to the vaccination may be slightly less effective. To compensate for this possible deficiency, a booster poliomyelitis vaccination is therefore offered at eighteen months, as well as on school entry, in order to ensure a satisfactory response.

Salk Poliomyelitis Vaccinations

	Year of Birth					Others under age 16	Total	Booster
	1967	1966	1965	1964	1960-63			
A.C.M.O's.	—	—	—	—	12	3	15	23
G.P's. ..	—	31	45	8	6	2	92	16
Total ..	—	31	45	8	18	5	107	39

Sabin (Oral)

	Year of Birth					Others under age 16	Total	Booster
	1967	1966	1965	1964	1960-63			
A.C.M.O's.	1435	274	67	28	254	166	2224	3672
G.P's. ..	1385	3041	449	127	272	182	5456	2967
Total ..	2820	3315	516	155	526	348	7680	6639

Smallpox

Smallpox vaccination should be carried out preferably sometime during the second year of life. Supplies of lymph vaccine can be obtained from the County Health Department. (Telephone 77977 Extension 514). Record cards also obtainable from the county health department, are completed by the doctors and returned to the county medical officer in respect of each vaccination carried out.

International certificates of vaccination (issued by the Ministry of Health), required before visitors are admitted to certain overseas countries, are submitted to the local district medical officer of health for the purpose of authenticating the doctor's signature.

The following table shows the number of vaccinations and re-vaccinations performed during the last five years.

VACCINATIONS							RE-VACCINATIONS						
Year	Under 1	1	2-4	5-14	15 or over	Total	Under 1	1	2-4	5-14	15 or over	Total	
1962	1839	3277	2339	8400	15404	31259	—	99	689	9380	32093	42261	
1963	526	1430	348	389	791	3484	16	28	106	557	2180	2887	
1964	463	2232	1012	106	363	4176	6	36	99	345	1672	2158	
Year	Under 1	1	2-3	5-15	Total		Under 1	1	2-4	5-15	Total		
1965	42	2013	1761	223	4039		15	10	156	528	709		
1966	435	2319	1989	322	5065		8	47	196	1037	1288		
1967	552	2279	1667	396	4894		—	32	111	922	1065		

Measles

Vaccination is not at present offered to children by the local authority. There are hopes that this will be changed in 1968.

Record Cards

Special personal record cards are issued to mothers attending welfare centres, and supplies are available to general practitioners on request. The importance of having these cards completed after each injection is stressed to the parents, who are also advised to produce it whenever a child attends a doctor or hospital following an accident. If the doctor has evidence of a satisfactory primary course of tetanus immunisation he will be able, under such circumstances, to give a booster dose of tetanus toxoid rather than A.T.S., and thus avoid the danger of serum sensitization.

Prophylactics can be obtained as follows:

<i>Vaccine</i>	<i>Centre</i>
Triple prophylactic Diph./Tetanus prophylactic T.A.F. Whooping cough Tetanus Oral polio vaccine Salk Polio Vaccine (if required)	County Health Department, County Hall, Topsham Road, Exeter (Tel. 77977, ext. 514). or in <i>small quantities</i> direct from Barnstaple—The Clinic, 19b Alexandra Road (Tel. 5137)— Dr. Williams. Bideford — The Clinic, Coronation Road (Tel. 3163) — Dr. Candler. Bovey Tracey Health Centre, Abbey Road (Tel. 2666). Buckfastleigh Health Centre, 7 Bossell Road (Tel. 2171). Budleigh Salterton Health Centre, 1 The Lawn (Tel. 2213). Crediton—The Clinic, “Newcombes” (Tel. 2649). Dartmouth—New Centre, Mayor’s Avenue (Tel. 2845). Exmouth—The Clinic, 89 Withycombe Road (Tel. 2610) — Dr. Anderson. Honiton—Municipal Offices, New Street (Tel. 391) — Dr. MacLeod. Ilfracombe—The Health Centre, Malborough Road (Tel. 3521)— Dr. Dunn. Ipplepen Health Centre, Biltor Road (Tel. 621). Lynton Health Centre, Burville Street (Tel. 3226). Kingsbridge—The Clinic, “Tresillian”, Fore Street (Tel. 2606). Kingsteignton Health Centre, Whiteway Drive (Tel. 3861). Newton Abbot—The Clinic, 21 Courtenay Park (Tel. 2445)— Dr. Davies. Okehampton Health Centre, Memorial Hospital Grounds (Tel. 731). Ottery St. Mary Health Centre, 74 Sandhill Street (Tel. 2288). Seaton Health Centre, Harepath Road (Tel. 877). South Molton—The Clinic, 99 East Street (Tel. 2352). Tavistock—The Clinic, Crowndale Road (Tel. 2617) — Dr. Budding. Tiverton—The Clinic, Rock Close, St. Andrew’s Street (Tel. 3341) Torrington Health Centre, New Road (Tel. 2282). Totnes—The Clinic, “Rosabelle,” Plymouth Road. (Tel. 3545).
Smallpox Vaccine	County Health Dept., County Hall, Exeter (Tel. 77977). (Ext. 514)

B.C.G. (Anti-Tuberculosis)

Vaccination is undertaken by the chest physicians for infants and young children exposed to infection from a known case of tuberculosis. B.C.G. vaccination is offered to school children of over eleven years of age, and also young adults attending colleges, technical schools, etc. Parents have the opportunity of giving their consent to this procedure and the vaccination is carried out by specially trained medical officers.

	School Children	Students Attending Further Education Establishments
No. of Children on Roll	7,433	—
No. of children for whom parental consent received	6,410	—
No. tuberculin tested (Heaf tested 2 mm. puncture)	6,079	—
No. positive	440	—
No. negative	5,480	—
No. given freeze-dried B.C.G. vaccine	5,420	—

TUBERCULOSIS

This year 73 cases were notified, a fall over last year of 49.

Age	Pulmonary		Non-Pulmonary		All forms T.B.		Totals				
	M	F	M	F	M	F	1967	1966	1965	1964	1963
Under 5	0	1	1	0	1	1	2	4	4	2	4
5—14	0	0	1	0	1	0	1	6	11	9	7
15—24	1	2	1	1	2	3	5	17	19	14	14
25—34	1	4	0	3	1	7	8	13	19	14	14
35—44	4	1	1	5	5	6	11	14	19	20	21
45—54	2	4	2	3	4	7	11	26	22	15	26
55—64	6	2	0	0	6	2	8	20	17	12	18
65+	15	4	3	5	18	9	27	22	19	23	13
Unknown	—	—	—	—	—	—	—	—	1	1	—
Totals	29	18	9	17	38	35	73	122	131	110	117
	47		26*		73						

*Includes 8 cases of T.B. glands, 5 abdominal, 6 genito-urinary system, 2 bones and joints, 2 meningeal, 3 others.

Detection

How Picked Up	Pulmonary	Non-Pulmonary	Total
G.P. to Chest Clinic	26	7	33
G.P. to Mass X-Ray	1	—	1
Contacts of known cases	1	—	1
Hospitals	13	18	31
Public Sessions Mass X-Ray	4	—	4
Tests (Heaf)	1	—	1
No information available	1	1	2
Totals	47	26	73

Contacts

Contacts examined							No. of cases of T.B. found
Houschold	Adults	..	..	..	..	80	3
	Children	..	..	..	..	48	—
Total household						128	3
Neighbours, friends or relatives not living in household							2
Contacts at work, in school or elsewhere							—

Every case of tuberculosis must have a source and every contact runs a higher risk than the general population of contracting tuberculosis.

Treatment—Chest Clinics. The work of the four chest clinics is summarised in the table below:

	Torquay	Barnstaple	Exeter	Plymouth	Total
Patients on Register 1.1.67	633	349	738	82*	1,802
New Notifications:					
(a) respiratory	19	5	18	9	51
(b) non-respiratory	5	12	7	Nil	24
Deaths	20	4	8	6	38
Patients on Register 31.12.67	533	240	436	59	1,268
First examination of suspects	1,056	113	687	419	2,275
Cases of T.B. found	35	3	12	6	56
Contacts examined	174	103	287	29	593
Cases of T.B. found in contacts	2	—	2	—	4
Contacts vaccinated with B.C.G.	77	53	108	16	254

*To conform to the new boundaries.

During the year Dr. W. E. B. Lloyd retired from Torquay after over twenty-four years as Chest Physician for the South Devon area, and his place was taken by Dr. R. L. Midgley, formerly the Medical Superintendent of Hawkmoor. Dr. J. T. Smyth took over responsibility for the medical supervision of Hawkmoor in addition to being Chest Physician for the North Devon area.

During the year 75 new notifications of Tuberculosis were received of which 51 were respiratory. This compares very favourably with the total for last year which was 130 and 103 respectively. With the diminution of new cases found there has been a fall in the number of contacts examined and the number of persons given B.C.G. vaccination. Dr. Adkins, however, has stated that he is rather disturbed by the fact that there have been cases of acute pulmonary

tuberculosis in younger females, a group which it had hoped would have been protected by the B.C.G. vaccination scheme. Fortunately in these cases the vigilance of their general practitioners and the ready access to X-ray facilities has resulted in early diagnosis and successful treatment. Dr. Adkins further reported that as the number of pulmonary notifications fall, the proportion of non-pulmonary cases increase; however, the majority of this latter group have long histories and the seeds of the present trouble were probably sown many years ago. This is borne out by the fact that the disease is virtually non-existent in children and is consistent with the low percentage of tuberculous reaction found on routine school testing and possibly justifies the partial drop of tuberculin testing in schools. Efforts toward the control and cure of tuberculosis should not be relaxed in any of its phases.

Dr. Midgley (South Devon) reports that although an increased number of suspects were examined, fewer new cases were found and the number of persons on the register fell to a new low level. As in other areas the fall in the number of tuberculous persons has meant a corresponding fall in the number of both contacts examined and persons given B.C.G. vaccination.

In addition to its primary function of tuberculosis control, the chest clinics deal with the diagnosis and supervision of other respiratory diseases and Dr. Midgley states that among new patients bronchial carcinoma is now more often seen than tuberculosis. Dr. Midgley concludes with the disappointing fact that of 5,000 appointments made last year more than 20% were not kept, which means a dissipation of effort by the clinic staff.

In West Devon a large part of the most heavily populated area of the Plympton Rural District Council was transferred to Plymouth City Corporation on 1st April, 1967. This of course has meant that there has been a large all-round reduction in the statistics for this area, and although it is not possible to make direct comparisons with recent years, it is obvious that the downward trend of registered patient notifications, examination of contacts and B.C.G. vaccination obvious in other areas is reflected in West Devon. This downward trend is also happily obvious in the North Devon area.

After paying tribute to Dr. Midgley for the reputation achieved and the high standard maintained at Hawkmoor during the period of his appointment there, Dr. Smyth reports that the volume of work done at Hawkmoor is largely unchanged compared with 1966. Of the 817 admitted, 90 were suffering from tuberculosis, 236 from cancer, 96 from bronchitis and emphysema, 38 from asthma and 457 from other diseases. 422 patients were admitted to the surgical unit. Of the 74 patients who died, 44 died from cancer and 8 from tuberculosis.

Dr. Smyth reported that there were no children in the hospital on 31st December 1967, but 18 children, including one tuberculous child, were admitted during the year.

These children were grouped clinically as follows:—

	<i>Tuberculous</i>		<i>Non-Tuberculous</i>	
R.A.I.	1	Observation	5	
		Pneumonia	2	
		Bronchitis	5	
		Bronchiectesis (no surgery)	1	
		Coarctation of Aorta	1	
		Neurogenic Tumour of Chest		
		Wall	1	
		Funnel Chest Deformity	1	
	—		—	
	1		17	
	—		—	

TUBERCULOUS CASE

* This patient did well on routine sanatorium treatment and chemotherapy during his two months' stay. There was no history of contact with an open case of tuberculosis.

NON-TUBERCULOUS CASES

Average length of stay two weeks, and all patients were considered fit to return to school after a period of convalescence.

No child of school age died in the hospital during the year.

HEAF TEST

Routine Heaf testing of all primary school children in 1967 followed by the examination of contacts of those showing positive results revealed only 1 case of tuberculosis, the mother of a school child.

In accordance with the decision reached in 1966, only school entrants were Heaf tested during 1967.

The figures for the year 1st November, 1966 to 31st October 1967 are as follows:—

	Found Positive on first testing	Converted to Positive on subsequent test	Total
Found Positive	45	3	48
Positive Children			
X-rayed	11	1	12
Contacts X-rayed			
(Adults)	13	—	13
(Children)	1	—	1
Cases picked up:			
Positive Children	—	—	—
Adult Contacts	1	—	1
Child Contacts	—	—	—
No. of schools tested—142. No. of children tested (all ages)—3,623.			

PART IV

LOCAL HEALTH SERVICES

Care of Mothers and Young Children

Midwifery

Home Nursing

Health Visiting

Home Help Service

Health Education

Ambulance

Adult Health

MATERNAL HEALTH AND NURSING

Maternity Services.

There have been many changes in the maternity services since the introduction of the National Health Service Act in 1948, at which time the Devon County Council took over the administration and staff of the domiciliary service from the Devonshire Nursing Association. The County Council continued the progressive outlook of the D.N.A. and soon all midwives were trained in the giving of analgesia and the attending of refresher courses to keep them up to date in their practice. All were encouraged to become car drivers and telephones were supplied to improve working facilities. To-day the idea of a domiciliary midwife without a car or 'phone is unthinkable.

In the county 7,395 births were notified during the year (as adjusted for transfers in and out)

Domiciliary	1,381
Institutional	6,014
	<hr/>
	7,395

1967 had a lower total of births for the third year in succession. This would appear almost wholly due to the loss of the Plympton and Plymstock areas to Plymouth. There was a further marked increase in the number of women discharged early in the puerperium from the maternity units. The great majority of these cases cause no anxiety to the district midwife but there have been a small proportion of women who discharge themselves against advice to unsatisfactory home conditions. So far, however, fortunately no harm has occurred to either mother or child.

Ante-Natal Clinics

During the year the health education classes at Plympton and Plymstock were transferred to Plymouth and new classes were started at Bere Alston, Ipplepen and Yelverton. There are now 41 clinics in which the district midwives and health visitors together give courses on health education, exercise and relaxation. About 38 per cent of the expectant mothers in the county attend these classes, most of these expecting their first baby. 2,821 mothers made a total of 10,979 attendances.

It is felt that the mothers at present attending are enthusiastic and appreciate the service, but there is obviously room for improvement in the attendance figures, particularly with those expecting their second and subsequent babies. In the busier centres staff are having difficulties in finding time to duplicate the sessions to meet the demand. Health education sessions are more time consuming than physical examinations as there is a considerable amount of preparation of talks and visual aids before each session.

Most expectant mothers, however, feel that individual advice does not meet all their needs and more and more they are asking for the opening of new centres. The demand is for group teaching and discussion in which husbands may also take part in at least some sessions.

Dental Care of Expectant and Nursing Mothers and their Children

During the year 850 pre-school children were examined and roughly half this number required treatment. While these figures are encouraging, inspection of five year old school entrants indicates that too many parents fail to seek a dental inspection for their children from the age of three. Mr. Shipley mentions the consequences when he states "The caries rate, particularly in pre-school children is high, often children brought to the clinic with toothache, are found to have four deciduous molars unconservable." Attempts are made by County Dental Surgeons, Dental Auxiliary and Dental Hygienist to inform parents of their responsibility to seek dental inspection for their young children before they enter school. Dental Health Education is included in the extensive programme of lectures given to ante-natal relaxation classes, and here again, the need for routine inspection of young children from the age of three is stressed. The ultimate responsibility remains with parents and Mr. Shipley underlines the difficulties which arise in many parts of the country in saying "The Okehampton Dental Surgeon's area is 90% rural with an almost non existent bus service into town. Thus, unless toothache occurs, pre-school children are not dentally examined until of school age."

The number of mothers who received treatment during the year was again lower than the previous year and it is assumed that most expectant and nursing mothers seek treatment from their own dental practitioner.

Dental Inspection and Treatment

	<i>Pre-School Children</i>	<i>Mothers</i>
No. inspected	850	105
No. found to require treatment	445	88
No. actually treated	382	84
Attendances for treatment	811	212
Fillings	688	160
Extractions	243	59
General anaesthetics	86	6
Prophylaxis	67	56
Teeth otherwise conserved	162	—
No. of dentures supplied	—	13

Family Planning

The Family Planning Act became effective on 28th June, 1967, and gave the green light to local health authorities to advise couples on both medical and social grounds on the various aspects of family planning.

Devon County Council has decided to continue making a grant to the Family Planning Association to undertake the necessary work on behalf of the local authority. The F.P.A. has agreed to give advice and supplies free of charge as required by the Act, to those women who seek advice on medical or obstetrical grounds. As local authorities are now required to permit the F.P.A. free use of the clinic premises it is obvious that increased grants in ensuing years will become necessary to meet the needs of this growing service.

Excellent relations exist between the local authority and the F.P.A. and whenever necessary there is ready discussion in regard to improving the service.

Cervical Cytology

During 1967 there has been a big drop in the number of women seeking this examination. Unfortunately those women who are thought to be most at risk of developing this type of cancer seem to be reluctant to avail themselves of this service. During the year 6,305 women attended the clinics and there were 22 positive smear results. All these cases were referred for further examination and, where necessary, they received treatment. The cytology sessions have, however, brought to light numerous other conditions needing treatment, and this has proved a valuable aspect of the survey. Where they wish women have both breast and urine examinations.

The special survey in one town has just been completed and Dr. June MacTaggart has prepared the following preliminary report. A more detailed analysis will become available at a later date.

“During the first 7 months of 1967 a cytology survey was carried out in the Dartmouth area of Devon County and during this time all women aged 25-60 inclusive living within the borough of Dartmouth were offered an appointment to attend the clinic for a cervical smear.

“1199 women were eligible for appointments and of these 1,033 attended the clinic, i.e. nearly 87%.

“Most of the women were very pleased to have been offered an appointment and many admitted that they would not have asked for one themselves but when the test was offered they were only too pleased to accept.

“A considerable amount of medical and clerical time was involved in carrying out this survey but the results justify all the time and trouble involved as about 10% of these women were found to have some form of gynaecological abnormality and were referred to their own doctors for further investigation or treatment.

“I feel that this survey was well worth while and that money should be made available for similar surveys to be carried out in other parts of the county.”

Care of Unmarried Mothers and their Children

The 597 illegitimate births actually constitute a percentage rise, although the total is less because of the change in the county boundaries.

The social agencies are still finding their work increases, particularly in regard to girls who come to Devon late in pregnancy, so as to keep their situation a secret from relatives and friends. Greater acceptance of the situation by the families of these girls results in smaller numbers needing admission to mother and baby homes. Inevitable rising costs offset the potential financial saving.

The social workers are directly employed by the Exeter Diocesan Council for Family and Social Welfare. The County Council makes an annual grant towards the cost of the work carried out by its workers.

During the year the council was concerned with 463 cases. 178 of these were referred by the health department. 24 girls were admitted to St. Nicholas House, Exeter, where five places are reserved for Devon girls and in addition

the county council accepted partial financial responsibility in respect of the maintenance of 27 girls in homes as follows:

St. Olave's Home, Exeter	12
Southview, Plymouth	6
Mayflower Home, Plymouth	7
Homes outside Devon	2
	<hr/>
	27
	<hr/>

Births

Registered live births numbered 7,419 compared with 8,179 in the previous year and an annual average of 8,196 in the quinquennium 1962-1966. The corresponding crude birth rates were 14.8, 14.6 and 14.8 respectively. For the third year in succession the total number of births has fallen after a steady annual rise since 1956.

The corrected live birth rates for the past ten years, which are figures adjusted by the factors applicable for the aggregates of boroughs and urban districts, rural districts, the administrative county, also the national rate, are given below:—

	Boroughs and Urban Districts	Rural Districts	Administrative County	England & Wales
1958	13.7	16.7	15.1	16.4
1959	14.2	16.8	15.4	16.5
1960	14.2	16.9	15.5	17.1
1961	14.5	17.0	15.1	17.4
1962	14.8	17.8	16.1	18.0
1963	17.4	18.3	17.9	18.2
1964	18.3	18.4	18.3	18.4
1965	17.7	18.4	18.2	18.0
1966	17.6	17.7	17.6	17.7
1967	17.6	16.8	17.2	17.2

Infant Deaths

Total infant deaths are very considerably reduced at 84. The greater majority of these again occurred in the first four weeks of life and are referred to in those sections. Only 30 occurred after the first month of life.

Infant Welfare Services

The vital stastics for 1967, set out in the form requested by the Minister of Health, are:

	Administrative County 7,419	England and Wales
Live Births:		
Number		
Corrected Rate per thousand population	17.2	17.2
Illegitimate live births (597) per cent of total live births	8.05	
Stillbirths:		
Number	96	
Rates per thousand live and stillbirths	12.77	14.8
Total live and stillbirths	7,515	
Infant deaths (deaths under one year)	84	
Infant Mortality Rates:		
Total infant deaths per 1,000 live births	11.32	18.3
Legitimate infant deaths (80) per 1,000 legitimate live births	11.73	
Illegitimate infant deaths (4) per 1,000 illegitimate live births	6.70	
Neo-natal Mortality Rate (deaths under four weeks (54) per 1,000 total live births	7.28	12.5
Early Neo-natal Mortality Rate (deaths under one week (44) per 1,000	5.93	10.8
Perinatal Mortality Rate (stillbirths and deaths under one week combined (140) per 1,000 total live and stillbirths)	18.63	25.4
Maternal Mortality (including abortion):		
Number of deaths	0	
Rate per 1,000 total live and stillbirths	0	

Stillbirths

These numbered 97 compared with 102 in the previous year. This shows the importance of considering infant deaths and stillbirths together.

Domiciliary	7 including	3 premature stillbirths
Institutional	90 including	54 premature stillbirths
	97	57

A stillbirth certificate is issued by the doctor in attendance in each case, but a considerable proportion are recorded as cause unknown. Without a post-mortem examination accuracy is often impossible.

The following table shows the comparative stillbirth rates for the county and England and Wales over the years:

	1959	1960	1961	1962	1963	1964	1965	1966	1967
Devon	17.9	19.0	16.9	15.0	16.9	17.3	15.9	12.1	12.8
England and Wales ..	21.0	19.8	19.1	18.1	17.2	16.4	15.7	15.4	14.8

Neo-natal deaths

Neo-natal deaths were 54 compared with 94 in 1966. Of the number who died 30 were premature, the greater proportion being of a very low birth weight.

The following tables shows comparative figures for the county and England and Wales from 1959:

	1959	1960	1961	1962	1963	1964	1965	1966	1967
County	13.8	14.3	11.0	11.6	13.6	10.8	9.1	11.5	7.3
England and Wales ..	15.8	15.6	15.5	15.1	14.2	13.8	13.0	12.9	12.5

Early Neo-natal (1st week) deaths

These numbered 44 of whom no less than 25 were premature.

The following table shows comparative rates for the county and England and Wales from 1959:

	1959	1960	1961	1962	1963	1964	1965	1966	1967
County	12.8	13.2	9.6	9.5	11.9	9.3	7.5	9.0	5.9
England and Wales ..	13.8	13.4	13.4	13.0	12.3	12.1	11.3	11.1	10.8

Perinatal Mortality

The term perinatal mortality describes the combination of stillbirths and deaths in the first week of life which provides an indication of the loss of infant life due to conditions associated with pregnancy and events during labour and delivery.

The following table shows comparative rates for the county and England and Wales from 1959:

	1959	1960	1961	1962	1963	1964	1965	1966	1967
Devon	30.5	32.0	26.3	24.4	28.5	26.5	23.3	21.0	18.6
England and Wales ..	34.2	32.9	32.2	30.8	29.3	28.2	26.9	26.3	25.4

Neo-natal, Early neo-natal and Perinatal deaths with seemingly lower rates are not truly comparable with previous years owing to the difficulty in evaluating figures with boundary changes being effective on 1st April and not at the beginning of the year being considered. Premature birth figures are likewise affected.

Premature Births

Premature live births totalled 436 compared with 474 for the preceding year. Four hundred and six of these survived the first twenty-eight days of life.

The following table shows the birth weight, place of birth and number of premature babies surviving in each group at the end of twenty-eight days:

Premature live births—Total notified 436																
Weight at birth	Born at home or in a nursing home															
	Born in hospital				Nursed, entirely at home or in a nursing home				Transferred to hospital on or before 28th Day				Premature Stillbirths			
	Died			Total births	Died			Total births	Died			Total births	Born			
	within 24 hours of birth	in 1 and under 7 days	in 7 and under 28 days		within 24 hours of birth	in 1 and under 7 days	in 7 and under 28 days		within 24 hours of birth	in 1 and under 7 days	in 7 and under 28 days		in hospital	at home or in a nursing home		
															(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
1. 2 lb. 3 oz. or less	13	7	2	—	—	—	—	—	—	—	—	1	1	—	13	1
2. Over 2 lb. 3 oz. up to and including 3 lb. 4 oz.	22	2	—	—	—	—	—	—	—	—	—	3	—	—	16	—
3. Over 3 lb. 4 oz. up to and including 4 lb. 6 oz.	76	—	1	3	1	—	—	—	—	—	—	1	—	1	10	1
4. Over 4 lb. 6 oz. up to and including 4 lb. 15 oz.	88	3	2	2	8	—	—	—	—	—	—	—	—	—	6	1
5. Over 4 lb. 15 oz. up to and including 5 lb. 8 oz.	190	2	3	—	33	1	—	—	—	—	—	—	—	—	9	—
6. Total	389	14	8	5	42	1	—	—	—	—	—	5	1	1	54	3

Child Welfare Centres

There are still seventy-five child welfare centres operating in the county, three centres having been transferred to Plymouth during the year and three new centres having been opened.

No. purpose built	15
No. adapted and in full time use	11
No. used on sessional basis	49

Mothers continue to make full use of the facilities available and 12,354 children made a total of 79,492 visits. Particular encouragement is given to the mothers of abnormal and handicapped children to make use of the clinic services regularly so as to receive all possible supervision and suitable counselling as to ensure the best possible development of the child concerned.

Phenylketonuria

Health visitors have been testing babies as a routine since 1st September, 1959. All mothers are advised of the reason for this test and almost all decide to have it performed for their own children.

Congenital Dislocation of the Hip (Ortolani test)

In addition to many hospital staff the district midwives and health visitors have all been advised of the method of testing hips of the new-born infant. During the year eight cases were detected and the children spared the prolonged treatment necessary when diagnosis is delayed.

Cases are still occasionally found when children have attained walking age. These children have all passed the Ortolani test soon after birth and this illustrates both the difficulties and disappointments which can occur in seeking to prevent the development of disabilities.

“At Risk” Register

This continues to be kept in accordance with the returns required by the Ministry of Health. No less than 2,748 out of the 7,419 births were placed on the register. Similar figures are being found in other authorities, but children are still found who develop handicaps and had not been on the “At Risk” register. Some of these had, in fact, histories previously undisclosed which showed clearly that they should have been on the register. This stresses the need to carry out a critical survey of all children in their early years.

Distribution of Welfare Foods

	National Dried Milk (Tins)		Cod Liver Oil (bottles)		Vitamin Tablets (packets)		Orange Juice (bottles)	
	1966	1967	1966	1967	1966	1967	1966	1967
Totals	51091	41985	5732	5059	5996	5771	93625	91148

Welfare Foods are issued from 56 child welfare centres, 5 W.R.V.S. centres and 143 shops and private houses. I should again like to express appreciation to the many voluntary workers who undertake the actual work of distribution at these 204 distribution centres and to officials of district councils and other departments of the county council who act as area depot officers.

Registration of Nursing Homes

No new nursing homes were registered during the year. Two proprietors returned the certificate of registration on retirement or change of usage.

At the end of the year there were 20 registered nursing homes providing 23 maternity beds and 281 medical, convalescent and chronic beds.

Nurses' Acts 1919-1945

Two applications for renewal of licences to carry on agencies for the supply of nurses under these Acts were received and approved during the year.

MIDWIFERY & HOME NURSING

With the changes made under the Boundary Commission recommendations, Plympton and Plymstock were incorporated into the City of Plymouth on the 1st April, 1967.

Seven midwives and six home nurses were transferred to that authority which reduced our total establishment to 175, plus the Superintendent Nursing Officer, her deputy and three Assistant Nursing Officers.

Of the total establishment there are 13 full-time midwives and 43 full-time home nurses, 119 undertaking combined nursing and midwifery duties.

There were few vacancies during the year; one nurse retired and one nurse died.

Attachment of Nursing Staff to General Practicices

During the year a pilot scheme was instituted in one area, where 8 nurses and midwives were attached to three group practices. The initiation of this scheme was brought about at the request of the general practitioners concerned. The doctors and the nurses were visited and carefully prepared for the changes which would result. With the unanimous agreement of the nurses involved, the scheme was commenced on the 1st June last and has proved satisfactory. Special records were kept for the trial period of six months, and these showed the work of the nurses became more varied in character and increased their job satisfaction in that they worked more closely with their doctors and had access to the doctor's records. It would seem that the main disadvantage was the increased amount of travelling.

Liason with General Practitioners and Maternity Units

The district nurses in rural areas have invariably worked in close liason with the family doctors, and this has always been encouraged. We are endeavouring to increase this close relationship.

The services of the domiciliary midwives have been called upon in a few areas to undertake deliveries in the smaller maternity hospitals, and we hope we may be able to give further assistance in the future. In this way the mother would be looked after by the midwife already known to her, the hospital would receive assistance when short of staff, and the domiciliary midwives would retain their skills of practice.

Midwifery

There are 13 full-time midwives and 119 combining midwifery and nursing duties.

The work of the midwives is summarised in the following table:—

Domiciliary deliveries attended	1,437
Nursing care of mothers discharged from hospital before tenth day	3,744
Attendances at G.P. ante-natal clinics	3,518
Attendances at County Council ante-natal clinics	1,716
No. of cases in which gas and air or gas and oxygen was administered	1,027
No. of cases in which trilene was administered	85
No. of cases in which pethidine was administered	834
Total number of midwifery visits	38,622
Total number of ante-natal visits	34,283

Equipment

All midwives have now been supplied with the up-to-date Entonox analgesic apparatus and the Minnitt machines which have been in use for about 20 years are being withdrawn from the service.

Recruitment

This has continued to improve, and there has been no serious shortage during the year.

Pupil Midwives

In September we undertook to train pupil midwives for Exeter City Council, and these are being trained in the Exmouth group.

HOME NURSING

There are 43 general nurses and 119 combining midwifery and nursing duties.

Recruitment

There has been considerable improvement in this.

Training

Three nurses, one being seconded, were given the Queen's nurse training at Exeter and were appointed to districts in the County.

In-Service Training

Eight days over a period of four weeks were given in four areas of the County, when all nurses, with the exception of those on sick-leave, attended. Lectures were given on each day by a medical consultant as well as demonstrations of nursing procedures, together with aids and appliances.

Lectures in Hospitals

These were given by the Superintendent or her deputy and assistants to student nurses at the North Devon Infirmary, the Torbay Hospital and the Royal Devon and Exeter Hospital. Lectures were also given to student nurses undertaking district training arranged by Exeter City Council.

Cases nursed

The work of the district nurses is summarised in the following table:—

No. of medical cases nursed	.. .. .	11,239	involving	274,734	Visits
No. of surgical cases nursed	.. .. .	2,515	involving	49,027	Visits
No. of infectious disease cases nursed	.. .. .	20	involving	76	Visits
No. of tuberculosis cases nursed	.. .. .	28	involving	1,012	Visits
No. of maternal complications nursed	.. .. .	233	involving	1,680	Visits
No. of other cases nursed	.. .. .	532	involving	24,262	Visits

These figures include 10,305 patients over sixty-five years of age, who received a total of 248,121 visits; 379 children under five received 2,167 visits; and 4,000 patients who each received more than 24 visits in the year, the total number of visits involved to these patients being 217,086.

The nursing of the elderly continues to be a major part of the nursing service, and there is little doubt that many people are able to stay in their own homes during terminal illness because of this service.

Co-operation with Voluntary Agencies

The report on the home nursing services would not be complete without mentioning the valuable work of the W.R.V.S. Meals-on-Wheels service, and also the Marie Curie Memorial Foundation Welfare Grants and night sitters service to patients suffering from cancer. Additional help from other voluntary agencies is also greatly appreciated.

HEALTH VISITING

The Superintendent Health Visitor is responsible for maintaining a high standard of health visiting including the organisation of the use and development of new ideas and procedures. She also has the important function of resolving the inevitable problems that arise from day to day with a large staff, and their personal happiness in their work.

At the end of 1967 there was an establishment of 86 health visitors which included 5 vacancies. There was a marked delay during the year in filling vacancies. Although 5 students completed their training and started work. 5 health visitors were transferred to Plymouth on the 1st April when their areas were taken over by that authority.

The health visitor groups were reorganised and there remained 9 groups instead of 10 as formerly. Each group has a group adviser who is herself a practising health visitor and she acts as a liaison officer to the whole group.

There are 19 clinic nurses and one nursing assistant, 4 of whom work full-time, 5 half-time and the remainder work school terms. They are employed within the group system and they relieve the health visitors of routine work in schools and perform certain duties in clinics.

All infants are visited as soon as possible after the tenth day, and further visits are made at intervals up to the age of five years. In the early weeks infants are examined for possible dislocation of the hips and the urine is tested for phenylketonuria. At six to eight months there is a simple hearing test; where there is any doubt a further visit is paid to retest and if necessary the child referred to the hearing assessment clinic. The health visitor is sometimes the first person to recognise that a child has a mental or physical handicap. She co-operates with the family doctor and other workers so that arrangements may be made to enable the child to make the best possible use of all faculties and to diminish, whenever possible, the effects of any handicap.

Health visitors and midwives together teach relaxation and mothercraft in the ante-natal clinics. In some parts of the county very successful classes for fathers have also been organised in the evenings. In the child welfare centres the health visitor advises the mothers individually and also carries out group teaching when possible. She assists the medical officers by her knowledge of the home background. The prevention of the spread of infectious diseases is one of her most constant duties and by stressing the need for immunisation and vaccination she endeavours to see that as many children as possible are protected. The health visitors assist the chest physicians to trace unknown cases of tuberculosis in the county by heat testing children when they enter school or newcomers who have not previously been tested. The contacts of positive reactors are traced and endeavours made to persuade them to attend for X-ray.

In the School Medical Service the health visitor is responsible for visiting the schools in her area; assisting in medical procedures such as school medical examinations. She sees that all school children have periodic vision tests, hearing tests and hygiene surveys. She is also available to help teachers to understand the home background of children who present a problem. Home visits are paid to parents of school children when necessary, special support being given to the families of handicapped children. Junior Training Centres and the school for physically handicapped children are also visited. The homes of handicapped children at residential schools are visited during the school holiday so that any problems may be discussed. The health visitors have assistance from clinic nurses in routine work in schools and clinics.

There are a large number of child minders and play-groups in the county area and the health visitor inspects and advises not less than thrice yearly.

There is in the county a hard core of problem families and the health visitors use every means in their power to try to improve the conditions in which these families live. Good team work is an essential factor in the attempt to rehabilitate them and there is close work at field level between the statutory and voluntary workers concerned with the differing facets that are shown in such cases.

The health visitors assist the Children's Officer by providing reports on prospective adopters and foster-parents.

Hospital consultants and medical social workers often request reports on home circumstances for patients with special problems who are ready for discharge. In some areas health visitors have also carried out or taken part in surveys to discover the number of people over the age of 65 years who live alone. In three areas in the county health visitors are now assisting in retirement clinics. In recent years there has been a steady annual increase in the number of home visits paid to the aged but there still remains a need to extend this work owing to the increasing number of aged in this county.

In some senior schools programmes of health education are carried out by health visitors. They co-operate with the current campaigns such as rescue breathing, smoking and lung cancer etc. in schools, clubs and other organisations. Many assist with the Duke of Edinburgh's Award Courses. In a few Senior Schools the health visitor is available at a specified time—usually the lunch hour so that any child may ask advice on personal problems. Talks are given to organisations when required.

Students from hospitals health visitor training schools universities and teacher training colleges accompany health visitors for varying periods for purposes of observation and practical work.

With the exception of one health visitor everyone is a car driver and so is able to get about her area with the minimum of travelling time. As each health visitor is on the telephone at home she can be contacted in emergencies by members of the public, doctors, or other workers.

Refresher courses are attended by health visitors every five years. Inservice training is also given in the form of study days, attendance at lectures and visits to mental hospitals etc.

Liaison with general practitioners has improved steadily over the years and generally there is a good working relationship. The majority of health visitors now have their case loads based on the families in group and single practices instead of geographical areas. They carry out their usual duties but there is also improved facilities for two-way co-operation between the family doctor and the health visitor attached to his practice. This results in closer co-operation and mutual benefit in their work of family care. A number of doctors have expressed appreciation of the help given particularly in relation to the health and social problems of the older patients. There are difficulties in that health visitors have high case loads and some practices cover a wide territory. Health visitors also assist family doctors who have their own well-baby clinics.

In areas where there is a County Council Clinic or Health Centre (Barnstaple, Bideford, Buckfastleigh, Budleigh Salterton, Crediton, Dartmouth, Dawlish, Exmouth, Holsworthy, Honiton, Ilfracombe, Kingsbridge, Kingsteignton, Lynton, Newton Abbot, Okehampton, Seaton, South Molton, Tavistock, Tiverton and Torrington) health visitors may be contacted between 9 a.m.-9.30 a.m. In centres where a clerk is employed, messages may be left in office hours to be dealt with by the health visitor later. Each health visitor is issued with visiting cards which show her home as well as any official address and telephone number. One of these cards is given to a family at a first visit. A new health visitor visits general practitioners and social workers of her area as soon as possible after taking up her duties.

A summary of the work undertaken by the health visitors during 1967 is given below:

<i>Type of Visit</i>	<i>No. of Visits</i>
Infants under one year	49,773
Children one to two years	20,193
Children two to five years	38,365
Schoolchildren	8,156
Age groups fifteen to sixty-five years	16,872
Expectant mothers	5,742
Tuberculosis	1,039
Aged	15,517
Mentally disordered persons	1,655
Under Children's Act	1,495
Patients discharged from hospital (not mental hospitals)	444
Attendances at centres, clinics etc.	7,608

HOME HELP SERVICE

Administration

Mr. G. P. Brooks works from County Hall, Exeter, and is responsible for the administering of the service throughout the county through area organisers and assistants. They are based at Health Centres and major Clinics in each of

the M.O.H. areas. At the end of 1967 the W.R.V.S. continued to run the service at Dartmouth M.B. Accounts relating to the service are raised in the Health Department and the county organiser is responsible for their collection by full-time collectors.

The Service in 1967

During 1967 some 5,353 cases were dealt with and details of these are given in the following table:

	Over 65	Under 65			Others	Totals
		Chronic Sick incl. T.B.	Mentally dis- ordered	Maternity		
D.C.C. Organisers W.R.V.S. (one)	4,097 58	311 4	47 —	390 5	434 7	5,279 74
Totals	4,155	315	47	395	411	5,353
Figures for 1966	3,786	422	41	484	411	5,174

At the 31st December 1967 there were 1,255 Home Helps employed—all part-time, with full-time equivalent 385.

The daily case-load at 31st December was 3,436 compared with 3,216 the previous year and of this number 2,905 were in the “over 65” group—slightly more than 83%—a slightly higher proportion than in 1966.

The service has developed much as was anticipated, particularly in the “over 65” group and this is likely to continue to account for the greater part of the service.

Liaison with Doctors and Hospitals

All general practitioners, medical social workers in hospitals, staff of the health department and all concerned with domiciliary care are informed of the address and telephone number of the home help organiser for the particular district in which a person requiring the service resides. A feature of the steady expansion of the service in recent years has been the increasing demand made by general practitioners and a growing awareness of the importance of the home help as a member of the home-care team. Hospitals too are coming to rely on the service more and more and all our organisers are experiencing a much closer working relationship with the hospital medical social workers.

Enquiries regarding the Service

Reference has been made to the fact that all doctors, hospitals, members of the staff of the Health Department etc. are informed how to contact the local organiser. Alternatively an enquiry addressed to the County Medical Officer, County Hall, Exeter, will be forwarded to the appropriate organiser. In urgent cases telephoned instructions will be given.

HEALTH EDUCATION

The health education unit has continued over the past year to support the work of the health department staff in the following ways:

1. Co-ordination of the health education activities of the health department field and headquarters staff.
2. Advice to local authority staff e.g. teachers, social workers and also general practitioners, voluntary agencies, students and others doing health education work, in the technique and content of health education.
3. Provision of equipment, visual aids and educational materials together with training in their use.
4. Training courses in health education and assistance with in-service training courses.
5. Evaluating and recording the result of health education activities and assessing health education needs.
6. Supplying information and reference material selected from professional journals, books, Parliamentary Acts, White Papers etc., which are maintained in the health education library.
7. Design and production of special art work for use as teaching aids, displays etc.

Equipment and Publicity

The unit maintains an increasing supply of teaching aids, cine films, filmstrips, posters, leaflets etc. The distribution of these materials is becoming more difficult and expensive each year and the technical equipment, cameras, slide and film projectors are more costly to maintain.

Talks and Programmes

- (a) *Smoking and health, venereal disease, family planning, drugs and drug addiction, personal relationships and cancer education (including cervical cytology)* are subjects which are introduced as talks on request only and are supported by the relevant visual material, leaflets and speakers.

This year the unit designed and had printed its own poster to publicise clinical examination and cervical cytology for women in the eligible age group.

- (b) (i) *Accident Prevention*

Promotion of accident prevention has been encouraged by a constant supply of publicity to all clinics, health centres, junior and adult training centres, schools, industrial concerns, and to individual student projects.

- (ii) *Home Safety*

In November the county was represented at the formation of the Regional Home Safety Committee, Area 13, covering local authorities etc., in Devon and Cornwall. Since district and other committees are also represented this will enable closer liaison with other health education agencies in Devon.

- (c) *Social Health Rehabilitation and Personal Relationship Course at Women's Borstal*

A 12-week series of talks, films and discussions took place in addition to the formal educational programme already being carried out for this section of girls, aged 16-19 who are mothers of small babies and often unmarried.

The talks are given by specialists and include subjects such as family planning, child development (Physical and Emotional), child care, venereal diseases and the prevention of diseases, personal relationships, emotional health, alcoholism and drug addiction, Local Authority Health & Welfare services, home economics and home safety. It is intended that the course is to become a permanent feature.

(d) *Dental Health Education*

This year it has been apparent that children are responding to the talks of the County Dental Hygienist.

Many teachers are now automatically doing a follow up session and using the materials, films etc., available from the unit. There also appears to be an interest in dental health by parent/teacher associations. In order to maintain appeal amongst specific age groups new material is constantly devised and added to the stock.

The practice has continued of including dental health education sessions in ante-natal classes and toddler groups. These sessions are popular and are thought to be very valuable in changing poor attitudes and dispelling bad habits.

(e) *In-service Training—Ante-Natal*

During the past year thought has been given nationally to the content and value of ante-natal education.

Devon is planning an in-service training course for midwives and health visitors. This it is hoped will provide even more interesting classes and so attract more parents.

The present talks to mothers-to-be consist of sessions on pregnancy, mechanics of labour, and relaxation and exercise classes.

(f) *General Talks*

The following list excludes talks at ante-natal and child welfare sessions:

Talks

Headquarters staff	99
A.C.M.Os.	12
*Health visitors	695
†District nurse/midwives	10
Dental officers	2
Dental auxiliary and dental hygienist	476
Occupational therapists	17
Social workers in mental health	14
Chiropodists	8
Speech therapists	7
Adult workshop managers	8
Home help organisers	11
‡Ambulance section	70

Key * Re-organisation by the introduction of group attachment to general practitioners could explain the drop as compared with figures in 1966 report.

† Excluding number of sessions for home nursing done by the nursing staff. (Ministry of Health circular 9/63).

‡ For first aid sessions only—as authorised by Ministry of Health circular 9/63.

Total audience attendance of these general talks in health education subjects is 18,124 approximately as compared with 14 491 of last year.

Trainees and Students: on observational visits and field work placement.

Student nurses (accompanying District nurse)	36
—1 day visits—	”
Student nurses (accompanying health visitors)	6
Social work students (to ATCs with OTs)	10
—13 daily visits each—	
Health visitor students	17
Health education students (1 week January 1 week March)	2

These placements have been made by the Universities of Exeter, London, and Bristol, also Technical and other colleges in the South West.

THE AMBULANCE SERVICE

Section 27 of the National Health Service Act, 1946, places on local health authorities the responsibility of providing ambulances and other means of transport, where necessary for the conveyance of persons suffering from illness, or expectant and nursing mothers, from places in their area to places outside their area. The words “where necessary” are generally interpreted as meaning the provision of transport to or from the nearest hospital at which the treatment required by the patient can be given assuming the patient is unfit by reason of mental or physical disability to travel by public transport. A further provision under section 27 allows local health authorities to delegate the provision of an ambulance service to the voluntary organisations.

The Devon County Council have taken advantage of this provision and have been very fortunate in being able to rely on the voluntary organisations of St. John, the British Red Cross Society and the hospital car service, to provide the service on their behalf.

The county council have entered into agreements with 32 local voluntary organisations in the county. Twenty-five of these organisations are St. John, five are Red Cross, one is a joint committee of St. John and the Red Cross and the other is an *ad hoc* committee made up of local people. This agreement provides for the local association to appoint and train such whole-time personnel as may be required to run the service in addition to the considerable number of voluntary members. All full-time personnel, therefore, are the employees of the local association, but the county council reimburse all running expenses of the ambulance service including staff salaries, provision of office equipment, the upkeep of vehicles, lighting, heating, rents and national and other approved insurances. The county council also provide the uniform for the full-time personnel. The number of vehicles owned by the associations has dropped from forty or so in 1948, to three at the present time, and it is the county council's policy to replace all locally owned ambulances by one provided by the county council. The county council now own sixty-four of the sixty-seven ambulances used on ambulance work. A provision of the agreement is that officers of the county council can inspect vehicles, premises, and personnel at any time. It is part of the county ambulance officer's terms of appointment to be responsible for encouraging and fostering the voluntary effort as far as possible and to ensure that whatever aid is required by the local associations in order to carry out their duties under the agreement, is given. Complaints concerning the service are reported both to the head of St. John or the Red

Cross and the county medical officer, who between them decide what action to take to remedy any shortcomings.

I do not think it is generally appreciated how much voluntary work comes into the provision of the ambulance service. Whilst a small call-out fee is paid to volunteers for the time they are actually working on the ambulance, no payment whatsoever is made for the enormous number of hours they stand by waiting for a call. There is also a large amount of voluntary work carried out by the officers of the voluntary organisations in arranging rosters, training, etc.

The majority of the sitting case work is carried out by the hospital car service. This consists of a number of private car owners who put their services at the disposal of the ambulance service. Nothing is paid to these drivers for the time they put into the service, but they do receive a small mileage allowance, which is agreed nationally, to cover cost of petrol, oil, and fair wear and tear.

Mention must also be made of the work put into the hospital car service by the area transport officers who receive all requests for sitting case transport, and who organise the journeys which are required. These persons spend a tremendous amount of time on this work and except for a very small clerical allowance do the work voluntarily.

The people of Devon should be grateful and proud of the fact that there are so many public spirited individuals available in the county to keep the ambulance and hospital car service working on these lines.

There are thirty-two ambulance stations in the county and they have been organised under four area controls at Barnstaple, Exeter, Plympton, and Torquay. These areas are more or less co-terminus with the catchment areas of the hospitals which they serve. By this means the majority of the ambulance journeys in one control area are made towards the focal point, namely the main hospital for the area. This lends itself to a better co-ordination of journeys. All ambulances and controls are equipped with two-way radio.

Emergency Calls

All emergency calls on the ambulance service are connected direct to the appropriate control office by the telephone service. It is important, therefore, that persons making an emergency ambulance call should carry out the instructions on the disc of the telephone upon which the call is made. In most parts of the county this means dialling 999.

Long Distance Journeys

British Rail provide excellent facilities for the transfer of stretcher and sitting cases. It is not generally appreciated that a stretcher case can travel much more quickly and comfortably by rail than by other means and that a special stretcher is available to ensure that the patient is able to travel the whole journey from door to door on one stretcher without being moved.

Infectious Diseases

Arrangements for the transport of patients suffering from infectious diseases are made from the following stations:

Torquay, Plympton and Barnstaple,
and in the case of East Devon by the Exeter County Borough ambulance service.

Smallpox

As the only smallpox hospital in this area is at Liskeard, Plymouth County Borough has undertaken to deal with any smallpox cases which might arise in the county.

Premature Baby Incubators

Premature baby incubators are kept at Torquay, Plympton, Barnstaple, and Honiton ambulance stations, and can be obtained by telephoning the appropriate ambulance control office.

Emergency Flying Squad

An ambulance is placed at the disposal of the emergency flying squad at the Torbay Hospital as and when required.

Air Transport

The arrangement for the transport of patients by air is covered by a Ministry of Health circular on the subject. The Minister's views, with which the County Council agrees, is that air transport should be used only in those cases where the local authority, on the advice of the Medical Officer of Health, is satisfied, after consultation with the medical practitioner (normally the Consultant) in charge of the case, that it is essential on urgent medical grounds, and that all other forms of transport have been considered and found to be impracticable. It is not thought that such cases will often arise. The County Council have been quite firm in their decision that they will only meet the cost of transporting patients by air when the authority's prior approval has been obtained.

Agency Arrangements with Exeter County Borough

The Devon County Council have entered into an agency arrangement with the Exeter County Borough Council whereby Exeter undertakes the provision of an ambulance service in those parts of Devon adjacent to Exeter and Devon undertakes the administration of the hospital car service within the City of Exeter. Appropriate financial adjustments are made.

Agency Arrangements with Plymouth County Borough:

The City of Plymouth have entered into an agency arrangement with the Devon County Council whereby Devon continue to provide the ambulance and hospital car services in Plympton and Plymstock.

Statistics:

	1966	1967
Ambulances		
Patients	80,238	81,492
Emergencies	8,674	9,526
Mileage	863,090	891,646
Hospital Car Service		
Patients	296,157	319,977
Mileage	2,780,691	2,947,235
Hired Cars		
Patients	7,222	10,079
Mileage	27,398	37,401
Totals		
Patients	383,617	411,548
Mileage	3,671,179	3,876,282

999 Emergency Ambulance Calls Received:

	1966	1967
North	703	843
Mid East	1,117	1,120
West	792	784
Torbay	2,823	3,399
Totals	5,435	6,146

Training:

The working party set up by the Ministry of Health on training and equipment of the ambulance service has now issued its reports. Experimental training courses are being organised by seven or eight authorities in the country, and we are sending members of our staff to these experimental courses. The Ministry of Health have intimated that an ambulance service instructors course will be held in 1968, and that one of the pre-requisites for attendance at this course will be attendance at the experimental course. We shall be sending three officers if possible on this course so that we shall then be able to provide our own instruction courses.

The working party has also made known its recommendations on the equipment to be carried in ambulances. There are one or two items of equipment recommended which are not carried in our ambulances at the moment, and provision is being made in the estimates to rectify this situation.

Air Transport

There were three occasions during the year when it was necessary for me to authorise the use of air transport. Two of these were emergency cases on Lundy Island, which had to be transferred to the North Devon Infirmary, Barnstaple. The third case was a patient with a fractured spine who had to be

conveyed to the specialist unit at Stoke Mandeville Hospital, and the only suitable means of transport was considered to be by helicopter.

Liaison with Hospitals

Meetings continue to be held with the staffs of the hospital groups in the county where common problems are discussed.

Rescue from Crashed Aircraft

During the year three training sessions were held at R.A.F. Chivenor, R.A.F. Mountbatten and Exeter Airport, where all personnel had an opportunity of receiving instruction in effecting rescues from crashed aircraft. All three instruction periods were very well attended.

Examination Successes

I am very pleased to report the following examination successes:

Associates of the Institute of Certified Ambulance Personnel

Mr. Webber, Assistant County Ambulance Officer; Mr. Evens, Assistant Ambulance Control Officer, West Devon; Driver Bourne, Torquay; Driver Russell, Sidmouth.

Institute of Ambulance Personnel

Associate Grade: Mr. Chick, Control Officer, Mid/East Devon.

Graduate Grade Mr. Brayley, Control Officer, North Devon.
Mr. Norrish, Assistant Control Officer, Mid/East Devon.

Ambulances and First Aid Services in War

This year has seen the closing down of the ambulance and first aid section of the civil defence corps. In its place the Ministry of Health are instituting an ambulance reserve and are arranging for the first aid services in war to be undertaken by the voluntary organisations. Meetings with St. John and the Red Cross have taken place and the County Commissioner and the County Director have both indicated the willing support of their organisations.

First aid and home nursing courses under Ministry of Health Circular 9/63, have been stepped up to a total of 25 for the year. These courses have been well attended and appear to be increasing in popularity.

THE CARE OF THE ADULT HANDICAPPED

The expansion of the adult health section continues. Some of the new developments over this period are as follows:

1. Work was commenced on the new adult training centres at Tavistock and Axminster.
2. Extensions to Hollacombe Adult Training Centre at Paignton were commenced during the year and by December 31st were almost complete. These extensions will increase the capacity of the centre from 60 to 120 trainees.

Social Workers in Mental Health

A comprehensive community care service for all types of mentally disordered adults has been in existence for many years in the county and the field

staff is 30 area social workers and 2 trainee social workers. The social workers are based on 15 centres throughout the county which is divided into four areas. These areas cover the catchment areas of a psychiatric hospital or of one of the proposed psychiatric units which are to be attached to the Barnstaple and Torbay hospitals where outpatient clinics are already in existence. The four areas are:

1. East and Central Devon (Exe Vale Hospital with additional out-patient facilities at Exeter and Axminster).
Social workers based at Budleigh Salterton, Exeter, Honiton and Tiverton.
2. North Devon (Barnstaple out-patient clinic with additional out-patient facilities at Bideford).
Social workers based at Barnstaple, Bideford and Ilfracombe.
3. West Devon (Moorhaven Hospital and the associated Nuffield Centre at Plymouth).
Social workers based at Plympton, Kingsbridge, Okehampton and Tavistock.
4. South Devon (Exe Vale Hospital and Torbay Hospital out-patient clinic with additional out-patient facilities at Newton Abbot).
Social workers based at Paignton, Torquay, Newton Abbot and Totnes.
5. There is also a joint appointment of Head Social Worker with the Exe Vale Hospital and Exeter City. This officer assists in the co-ordination of the work of three authorities.

Total Case Load (all types of Mentally Disordered Persons)

	1963	1964	1965	1966	1967
Total Case Load	2,407	2,469	2,543	2,556	2,389*

*Transfer of part of Plympton R.D.C. to Plymouth C.B.

The active individual case load of social workers is large and although the number of social workers employed is increasing annually we have never been able fully to satisfy the demand for community care.

Visiting and care of mentally retarded children in this county is provided mainly by the health visitors. The social worker is called in where there are special problems or to arrange admission to a psychiatric hospital. This arrangement is economical in manpower since the health visitor is often visiting the home of the handicapped child either to see another child of the family or perhaps an older relative.

Analysis of Referrals to Social Workers

Sources of referral of all categories of new patients	1963	1964	1965	1966	1967
General practitioners . .	747	736	979	1,217	1,391
Hospitals, on discharge . .	380	626	539	529	521
Hospitals, Out-Patients Dept.	386	449	437	330	195
Police and Courts	54	44	72	146	126
Other Sources	341	267	313	300	387
Total referrals	1,908	2,122	2,340	2,522	2,620

These figures give a very clear indication as to the growth of the community care service.

Moorhaven Hospital (for the Mentally Ill)

Dr. F. E. Pilkington, Physician Superintendent of Moorhaven Hospital in his annual report states:

“A comprehensive mental health service can be regarded as having two main parts: one, that part which is mostly concerned with in-patients; and two, the associated psychiatric services which deal with out-patients, day patients, domiciliary consultations, ward consultations, court work and examinations under the Mental Health Act. Follow-up and after-care of discharged in-patients is also of great importance whether this is done by doctors, social workers or nurses. It is most desirable that there is no administrative or clinical separation between the different parts of the service. Any such dichotomy would impede the ease of movement of patients from one part of the service to the other according to the clinical or social needs of the moment. Continuity of care by the same personnel wherever the patient may be is considered to be of overriding importance.”

Exe Vale Hospital Group (for the Mentally Ill)

Dr. Lewis Couper, Medical Co-ordinator-Consultant Psychiatrist, Exe Vale Hospital Group, has reported as follows:

“One of my greatest difficulties in the community is the finding of accommodation for patients. We are very well aware of this great shortage for the elderly and I am quite certain that the day must come when accommodation for the elderly must come under one head only, as it is quite apparent that the different services i.e. general practitioners, welfare, specialists, psychiatrists, medical officers of health departments, are all using their own ‘empire’ for their own advantages. So far as the mental hospital is concerned, there are too many people there who do not require the skill and care of either the psychiatrists or the psychiatric nurses, but so watered down are these services that great difficulty is found in diverting this special care to where it ought to be.

“As to the younger element, i.e. those on parole, chronic Schizophrenics fit for discharge from hospital, deteriorated alcoholics etc. an effort must be made, knowing how we are overwhelmed by the previous subject (the elderly), to accommodate this younger element in the community.

“May I once again state on behalf of myself and my staff how much we appreciate the friendly, helpful co-operation received both from yourself and from your department.”

Mental Illness

No. of Social Workers Visits	1963	1964	1965	1966	1967
Known mentally ill adults in the community ..	1,480	1,560	1,673	1,505	1,612
Visits to patients	12,620	14,415	17,868	20,599	22,981

Social Worker Visits in respect of Hospital Admissions and Discharges of the Mentally Ill

Mental Health Act 1959	Exe Vale Hospital	Moorhaven Hospital	Out-County Hospitals	1963	1964	1965	1966	1967
Informal Patients (Sect. 5)	1304	133	2	1198	1537	1471	1263	1439
Observation (Sect. 25)	114	26	—	126	131	151	188	140
Treatment (Sect. 26)	19	25	—	25	19	17	30	44
Emergencies (Sect. 29)	275	9	1	283	294	312	349	285
Courts (Sect. 60)	15	—	1	14	12	19	10	16
Total Admissions	1727	193	4	1646	1993	1970	1840	1924
Total Discharges	1217	132	—	1514	1803	1604	1332	1349
*Re-admissions (included in the totals)				482	717	519	281	369
Visits by social workers in respect of admission				3477	3706	4090	3929	3727

The senior area social workers are responsible for the day-to-day administration of the service in their particular area and are co-ordinating the work of their social workers in order to provide economy of individual effort.

Social Work Training

The Health Committee encourages the further training of staff. During the year two officers attended Council of Social Work Training Courses. Exeter University uses officers of the department as placements for its graduate students and Moorhaven Hospital also uses these facilities in connection with social worker students. The section's services as a whole are used by Exeter University to give their students a general insight into the working of the social services. The St. Lyses School of Occupational Therapy sent occupational therapy students to the department for placement as part of their training.

Medical officers, social workers, occupational therapists and training centre staff continue to give lectures to various associations and societies who are interested in the work carried out within the department.

Voluntary Organisations

The Women's Royal Voluntary Service offer their visiting service in association with the psychiatric hospitals and social workers in mental health. The members visit patients in hospital and, with the consent of the patient, at home after they have been discharged.

The club run by the W.R.V.S. at Exminster Hospital maintains its popularity with the patients, and fulfils a most necessary function in operating a trolley shop which visits about 20 wards on four afternoons each week.

The shop and canteen at the Royal Western Counties Hospital, Starcross, continue very successfully.

Royal Western Counties Hospital (for the Mentally Subnormal)

Dr. D. Prentice, Medical Superintendent and Consultant Psychiatrist reports:

"The Royal Western Counties Hospital Group continues to provide care and training under medical supervision for about 1,700 mentally disordered patients, most of whom suffer from a degree of subnormality as defined in the Mental Health Act, 1959, whilst one or two have been admitted from the Courts more recently suffering from psychopathic disorder.

"The largest hospitals in the Group are at Starcross and Langdon, near Dawlish. At Langdon there are now 552 beds and at Starcross 553. At present under construction is a new villa (2 x 30 beds) at Langdon. At these hospitals patients and staff are engaged in a wide variety of activities under the supervision of the nursing, artisan, catering, occupational and industrial therapy, agricultural and horticultural staffs. Many of the patients, after going through the training scheme, go to employment locally on a daily basis.

"Recreational activities are varied as much as possible and include regular games instruction, whilst matches are played on first-class cricket, football and hockey pitches. Patients who are able, enjoy swimming, country dancing and netball. The usual indoor entertainments such as shows, cinema and television, billiards and snooker are available to patients.

"There are also eight similar units in Devon and Cornwall, three of them with over 100 beds being Box House Hospital, Axminster; Western Hospital, Crediton; and the Retreat and Treleigh Hospitals, St. Columb Major. Three of the hospitals are designed for the care of a particular class of patient, Franklyn Hospital, Exeter, mostly for cot and chair children; Stoke Lyne Hospital, near Exmouth, now houses the Courtenay School and the Elizabeth Barclay Hospital, Bodmin, for geriatric patients. There are two hostels for male patients who are being trained for farm situations. There is a female hostel at Paignton for patients nearing return to the community and able to undertake domestic employment daily. There is a holiday home at Teignmouth for female patients and a summer Holiday Camp at Brixham which is occupied fully from late May until early September each year. During the holiday periods, when a number of patients go to their own homes, it has been found possible to offer short term care to mentally subnormal persons who are normally looked after at home. This affords relief for holidays to be taken by relatives.

"The Hospital Group has always regarded hospital and community care as complementary to each other and, while individual patients may be adequately trained in one or the other, many require and benefit from their combined services in enabling them to develop their full potential. Thus a close integration of the activities of both is essential if efficiency is to be achieved in the best interests of the patients concerned. This integration is effected by regular liaison and co-operation between the Hospital Group, the County Health Department and other Local Health Authorities in the catchment areas. Liaison Meetings are attended by Medical Officer of Health, Senior Mental Health Officers, and Medical and Administrative Officers of the Hospital Group and Regional Hospital Board. The Medical Officers of Health are represented by their inclusion in membership of the Hospital Management Committee and the Medical Superintendent of the Hospital Group, a Consultant Psychiatrist, serves as a member of the Devon Adult Health Sub-Committee. Weekly case conferences are held at which the Hospital staff meet mental health, probation and other officers for discussion of difficult cases and the most suitable form of

care or treatment for particular patients. From time to time Local Authority Social Workers accompany the Hospital Consultants when making domiciliary visits, and the after-care, which is so essential in making the discharged patient socially viable, is undertaken by the County Mental Health Officers directed by the Senior Medical Officer for Adult Health.

The first Clinic for the Mentally Subnormal in Devon was held at the Buckfastleigh Health Centre in December, 1967, and regular clinics are now being planned.

“The maintenance of close and friendly contacts between the Royal Western Counties Hospital Group and the County Health Department continue to be of considerable value.”

Care of the Mentally Subnormal in the Community

The social workers in mental health are responsible for the care of all mentally subnormal adults in the community. Assessment panels are held at which those cases of young subnormal persons who have been discharged from special schools or junior training centres are discussed with a view to arranging for future care and training as soon as possible. Medical officers, social workers, school teachers, educational psychologists, youth employment officers and workers from other agencies are invited to these panels to decide what is best in the interests of the individual. Apart from employment the Ministry of Labour Rehabilitation Units can offer courses where these young people can learn a basic trade, or we can offer our own training centres or domiciliary occupational therapy outwork.

Subnormal School-leavers

	1963	1964	1965	1966	1967
Number of special school and junior training centre leavers placed under community care	42	59	30	42	39
Number of children classified as educationally subnormal leaving secondary schools and placed under community care	34	46	20	27	30
TOTALS	76	105	50	69	69

Subnormal Adults

	1963	1964	1965	1966	1967
Discharged from hospital to community care	67	38	89	11	30
Guardianship cases	1	1	1	1	1
Discharged from community care	39	65	76	103	144
Total visits by social workers	4,178	4,232	4,562	4,134	4,603
Total active case load	927	909	922	851	775

Hospital Admissions and Discharges of the Subnormal

Mental Health Act 1959	R.W.C. Hospital	Special Hospitals	Out-County Hospitals	1963	1964	1965	1966	1967
Admissions: Informal Patients (Sect. 5)	35	—	3	54	48	25	19	38
Observation (Sect. 25)	—	—	—	1	—	1	1	—
Treatment (Sect. 26)	1	—	—	4	2	—	—	1
Emergencies (Sect. 29)	—	—	—	—	—	2	—	—
Courts (Sect. 60)	5	—	—	11	9	8	7	5
Total admissions	41	—	3	70	59	36	27	44
Total discharges				*41	*55	*46	*16	*44
Temporary hospital admissions (not exceeding two months)				29	27	19	9	18
Visits by social workers in respect of admissions				124	141	130	108	150

* Includes 11 (1963), 10 (1964), 12 (1965), 5 (1966) and 4 (1967) persons technically discharged but remaining resident informally in hospital.

Hospital Waiting List of the Subnormal

	Boys	Girls	Men	Women	Total
1963	12	7	11	3	33
1964	14	9	10	4	37
1965	18	12	14	5	49
1966	17	11	16	5	49
1967	17	8	14	9	48

ADULT TRAINING CENTRES

Generally the year has been one of consolidation and progress. There are now eight adult training centres in the county, only two of which (Tavistock and Kingsbridge) are not open five days a week. During the year further education and social training units were established in the newly-built premises at Doyle Centre, Exmouth.

The policy continues of introducing new materials into the training centres as and when appropriate so that trainees are made aware of modern material and production methods.

520 handicapped persons attended the centres regularly during the year and the total income from the sale of products was £50,070. While the economic side of the adult training centres is very important one must not forget the very considerable value of the social aspects of the training centres.

East Devon Group (Exmouth, Colyton, Crediton)

The new Doyle Centre at Exmouth was officially opened in April. The centre was running very smoothly at the end of the year—thanks to the hard work of the manager and staff following the transfer to these purpose-built premises.

The Crediton centre continues to work at full capacity. The main lines of production are still boxes and disposable paper goods.

The Colyton centre continues to function in the Church Hall and in spite of difficulties is being well supplied with suitable work.

Paignton (Hollacombe)

Lack of space continues to be a handicap but by the end of the year the extensions were well on their way to being completed.

Kingsteignton

These premises are hired during the daytime only but fortunately one room is entirely at our disposal so that permanent fixed machinery can be installed there. The making of gift boxes with acetate lids is being developed here and this again illustrates the value of staff who are imaginative and capable of improvising.

Barnstaple (Hawley)

The undoubted benefits of such new buildings as Hawley cannot be easily measured but we can of course ascertain the income from sales. The income for 1965 when this centre operated in two separate premises was £9,760; in 1966 the income was £18,750 with no appreciable increase in the number of trainees attending. In 1967 it had increased to £20,550.

West Devon Group (Kingsbridge, Tavistock, Plympton)

There was little change in the operation of the Kingsbridge and Tavistock centres during the year. The building for the new centre at Tavistock was commenced in July and by the end of the year was well advanced. Due to the boundary changes the Plympton centre was absorbed into Plymouth County Borough in April 1967.

Sheltered Workshop (Oakleigh Road, Barnstaple)

This workshop, approved by the Ministry of Labour, now has 15 approved workers which is the physical capacity of the building. More machinery was installed during the year which made it possible to manufacture a wider range of articles.

Dental Inspection and Treatment of Trainees attending Adult Training Centres

The scheme is now established at each Adult Training Centre and all centres with one exception where illness of the Dental Surgeon intervened, were offered treatment in the year. The amount of treatment provided is as follows:

Number examined	131
Number requiring treatment	88
Number treated	74
Attendances for treatment	205
Fillings	60
Extractions	53
Prophylaxis	35
Dentures	19
General Anaesthetics	7

Some trainees already receive treatment in the general dental service and only those who do not, are inspected and are offered treatment where this is found necessary.

Training for Supervisors of Adult Training Centres

There is establishment for two trainee supervisors in the county, who are attached to various training centres and other departmental sections for training. At present one is away on a course of training and the other is making application for a course in 1968. With the co-operation of the Exeter Technical college the course leading to a Technical Teacher's Certificate devised last year was continued with great success and was run on two evenings a week over one year. In the examinations held in 1967, 75 per cent of the students were successful.

Therapeutic Social Clubs for the Mentally Disordered

The therapeutic social clubs in Devon continue to flourish. At each club a committee, including patients, is formed and, guided by the social workers, decides the club's affairs and manages all financial arrangements. The clubs meet one evening each week and various forms of entertainment are arranged. The social workers in attendance are able to offer advice and guidance to those members who require it, and other helpers include occupational therapists, health visitors and home help organisers.

The Barnstaple Club, known as the Stepping Stones Club still takes advantage of the accommodation afforded by the Hawley Adult Training Centre, where they hold their meetings from 7.30-9.30 p.m. Club activities are as varied as possible, and include social evenings, indoor games, groups of entertainers, film shows and talks. In addition, several members still undertake some form of handicraft at home, the materials being supplied at cost price through the department.

The Bideford Club, known as the Torridge Friendship Club, continues to hold meetings at the local Moose Hall and has a very active committee. A social worker is normally available at the meetings but members themselves organise and arrange the activities. The Women's Royal Voluntary Service and British Red Cross Society continue to support the Club by offering transport facilities.

The Paignton Social Club which is held at Midvale Road Clinic continues to be most successful, as does the Torquay Social Club held at Owendene, Albert Road, from 7-9 p.m. Entertainment at both these clubs varies. They are very well attended and the members arrange a varied programme. An annual

outing and New Year's supper party and Christmas dinner and dance were very successful.

People who suffer mental breakdown tend to become over-preoccupied with themselves and their symptoms, and because of this many of them experience difficulty in meeting and mixing with others. Besides giving members the opportunity to mix and meet in sheltered environment the club stresses the value of an "outward" interest in life. This manifests itself in the coach and theatre outings—"helping others" and the insistence that members run the club themselves. The Torquay club has a very active and efficient members' committee.

In assessing priorities, account has had to be taken of the needs of about a hundred people returned to the community during the past two years who had spent an average of over 20 years in Exe Vale Hospital. The present day world for these people is very bewildering and they need special assistance in adjusting to it. The social club has proved helpful in this respect but the club's age structure has changed so that it has now taken on the appearance of an old people's club and this has discouraged the attendance of younger persons. The answer is a club for the younger age group but the social workers' duties are too extended at present to organise another club.

Tavistock Club

The meetings of the Youth Club for the Handicapped are now held weekly in the new Youth Centre where naturally the facilities are excellent.

HOSTELS FOR ADULT SUBNORMAL PERSONS

There are two hostels for adult subnormals, at Ocombe House, Marlton and Hawley House, Barnstaple.

Each hostel has a House Committee of local district and county councillors who work with the staff and local voluntary organisations for the well being of the residents. They are able to make recommendations to the Adult Health Sub-Committee with regard to running and equipping the hostels. We are most fortunate in having several organisations and societies interested in the two hostels and much is done to help the residents, both in a financial and practical way especially during holiday times.

All residents at the hostels receive 18/- from their social security allowance, together with a small wage for either working in the hostel or at an adult training centre. On admission to a hostel the residents open a Post Office savings account and are encouraged to save for holidays and personal effects.

Ocombe House, Marlton

This hostel, which accommodates 11 female and 12 male residents, is staffed by a warden and matron; deputy matron; resident cook/housekeeper and gardener/handyman who works on a daily basis. The deputy matron lives in only when required on normal duty.

During the year 3 female and 4 male residents were admitted—3 from parents' homes; 2 from hospital and 2 from normal homes on a short-term basis. 8 residents were discharged—3 males and 5 females—2 at parents' request; 3 at own request; 1 because she was unsuitable at the hostel and 2 who were on temporary short stay. 4 residents were working in full-time employment.

At weekends nearly all the residents visit local towns for entertainment. On Tuesday evenings many attended the leisure club at Hollacombe Adult

Training Centre and on alternate Mondays there is a social evening at Paignton organised by the Torbay Society for the Mentally Handicapped.

Hawley House, Barnstaple

This hostel is staffed by a matron and warden, deputy matron and warden, daily cook and assistant cook. The hostel is attached to a 120-place adult training centre by a kitchen which serves both establishments. The matron and warden are responsible for the kitchen and in preparing meals not only for the residents of the hostel but also the training centre and the local "meals on wheels" service. The accommodation available is for 27 adults—19 males live in the main building and 8 females are accommodated in an annexe some thirty yards from the main building. The deputy matron and warden sleep in a small flat in the annexe and have a sitting room in the main building. During the year one patient was admitted from hospital and 3 from their homes. At present there are three persons in full-time employment and other residents either work in the hostel or attend the adult training centre. Residents are taken out by the staff at weekends and holidays and for this purpose the training centre minibus is used.

OCCUPATIONAL THERAPY

Staffing

The establishment for the year was for 22 occupational therapists but 6 vacancies remained unfilled at 31st December resulting in the Torbay and Exmouth areas being undermanned.

Two technicians work with the occupational therapists in the assessment and training of those less able both physically and mentally. They also supply a much needed male influence in this section. Whilst assisting in the unit the technicians undertake the manufacture of custom-made aids and gadgets for individuals. Previously, the client went without these or had to wait a very long time for them. The technician works to the therapist's specifications, and also accompanies the occupational therapist to the client's home to give advice and to fix the required aid. It is often difficult to get a builder to do small jobs quickly and by using technicians the patients' needs are more quickly met. Many aids—unobtainable elsewhere—have been produced.

Domiciliary Service

The county's domiciliary occupational therapy service has continued to be in great demand and there were some 2,000 cases on the register at 31st December. Aids to daily living and advice on structural alterations take up the greater part of the therapists' time but this work is most rewarding. It is essential that clients are taught to use the aids supplied correctly and with confidence. The therapists pay regular check visits to all clients with aids and supervise their continued maintenance. The therapists continue to visit patients with aids issued by hospitals and voluntary associations—some of these many years ago. Due to wear and tear these aids may have become dangerous. A worn rubber on a stick or crutch can let down the owner who may treat it with complete confidence. Similarly, aids issued in a hospital or clinic may not be suitable for the home. A tripod may fill the need in a physiotherapy department where the floor is level, but it could be a menace on an uneven tiled floor or a broken surfaced path.

It would appear there are many elderly and severely handicapped persons at home who are not functioning as well as they might. Bed-lying and invalidism are still accepted as logical and legitimate—often when the degree of disability does not warrant this. The factors governing such an attitude are:

1. The visits of the therapist are looked on by the patients, the doctor and the therapist as being palliative rather than definite and prescribed treatment;
2. Relatives are often unprepared to give time and trouble to patients to teach them to help themselves and find it easier to do things for them. Later when through frustration the patient becomes either a parasite or a tyrant, relatives cannot see that they are largely to blame;
3. The desire of social and medical workers to give the patient props—often unnecessarily—and to relieve him of any duty or action that is difficult or unpleasant. There appears to be a great urge on the part of field workers and therapists to do something—concrete—to be kind to the patient rather than undertake the initially more unrewarding task of re-educating him;
4. The difficulties of an individual locality—often lack of help to get a patient in and out of bed means that he remains in bed all day. There is a great need for a more co-ordinated and intensive care in the early stages of the handicap to ensure that patient and family fully realise how much each can contribute to the home community.

It is essential to start training the handicapped as early as possible as they will have to work far harder to achieve the same results as their contemporaries and the relatives must be given adequate aids to relieve all physical difficulties. They will need every ounce of energy to encourage help and guide the patient.

Number of patients receiving domiciliary occupational therapy in 1967—2,025

	Boys	Girls	Men	Women
Physically disabled	26	12	654	1,126
Mentally Ill	—	—	49	30
Mentally Subnormal	8	7	41	65
Severely Mentally Subnormal	5	2	—	—
TOTALS	39	21	744	1,221

Rehabilitation Training Units

At Colyton an occupational therapist attends one day a week but can provide only very limited activities owing to a lack of facilities.

At Kingsteignton and Hollacombe there has been no space available to form a unit. At Tavistock the therapists are now able to give three full days a week but facilities are limited. The unit at Crediton has been able to continue at five days a week but the space is very limited—the unit being sandwiched between the kitchen and the workshop with their noise and traffic does not provide ideal conditions.

At Exmouth the unit continued to operate on only two days a week and will continue to do so until a full-time occupational therapist is appointed.

At Hawley the training unit operates five days a week and has splendid facilities. A wide range of activities has been organised. There is excellent liaison between the unit and hostel, and when girls have been brought to a fair standard of reliability in domestic work, the matron accepts them to work in the hostel where the routine is more like that of a small guest house and where they are subjected to greater work pressures.

All new trainees pass through the unit for assessment. Much of the work here is experimental regarding methods and activities and calls for continued re-appraisal. The staff are constantly bringing forward new projects for discussion and are most enthusiastic.

Therapeutic Clubs for the Handicapped

There is a need for creative and satisfying activities for the elderly. This has always been apparent and will increase. Although there are social clubs, rest rooms, etc., there are still some people who cannot be accepted into them, either because of being very severely handicapped or because of an awkward personality. Such groups must necessarily be small and be organised by a person trained to accept the fact that these people need help and are not merely setting out to be awkward.

A pioneer group at the unit at Hawley each Tuesday afternoon is run by two occupational therapists in rota. It is run on club lines and the participants are encouraged to take as much responsibility as possible. Besides arranging craft and remedial activities they undertake recreational and intellectual sessions and are encouraged to organise their own activities. About 20 people from the area attend according to their needs—some each week and some fortnightly. The relatives also benefit by having a periodic afternoon free. On return home the club member has new things to talk and think about. The therapist's work load is also relieved by seeing a number of her cases at this group, therefore cutting down on home visits. Work can also be provided at the club for members to take home. This is often a group project for some charity.

Pre-School Handicapped Group

This small group was instigated to help both parents and their handicapped children at an early age. The actual organisation of voluntary helpers, transport etc., is carried out by a member of both the Handicapped Association of North Devon and this pre-school group. The occupational therapists give advice and control the activities. The centre operates each Monday and Thursday afternoon.

Outwork

The provision of paid outwork for the home bound has proved extremely difficult. Those living within easy reach of a training centre are fairly well served and can earn a reasonable amount, but those living at a distance suffer because of the delay in the return of the work.

The spasmodic flow of work is a great problem and a cause of frustration. The therapists are sometimes criticised for not filling the gaps with craft work but after years of struggle to wipe out the "Wool Lady" image this is perhaps forgiveable; in fact the preparation and finishing of craft work takes up much of the therapist's time.

Shortage of Occupational Therapists

The therapists have done much during the past year to further both the education of therapists in training and to recruit school leavers to take up the profession. Groups of young people have been given a chance to see therapists at work and information has been given to careers teachers and conventions.

THE CHIROPODY SERVICE

The demand for this service continued to grow during the past year. The total number of patients waiting for treatment at 31st December was 862. The distribution of this waiting list throughout the county is as follows:

South Devon	393	This area includes Dartmouth, Kingsbridge, Buckfastleigh, Ashburton, Torquay, Paignton, Brixham, Newton Abbot, Teignmouth and Dawlish.
East Devon	360	This includes the area east of Tiverton and Crediton.
North Devon	86	This includes that part of Devon north of a line drawn a little south of Holsworthy to South Molton.
West Devon	23	This area includes Okehampton and Tavistock.

In December 1967, 122 clinics were operating throughout the county and during the year approximately 57,000 treatments were given by 18 chiropodists.

In the 1967 annual review the Health Committee recommended an increase in establishment of six chiropodists, but this was not approved by the Establishment Committee who deferred this item. Consequently the whole chiropody position had to be reviewed and it became apparent that in the present economic climate if the normal system of accepting applications and method of treatment continued, then a breakdown in the service would be unavoidable.

Several methods of reducing the waiting lists were considered but it became clear that the best method was to set up an appliance-making laboratory. A pilot scheme for three chiropodists was run and proved very satisfactory. In addition to the interval between treatments being increased, there was the additional factor of patient's comfort and eventually a larger percentage of discharges.

The only chiropodist trained in appliance-making worked in the East Devon area, and normally he would have been replaced before his clinic services were partly withdrawn. However, the lack of extra chiropodists, the need for economy, the expanding waiting lists and, not least, the prolonged illness of a chiropodist meant an accelerated programme and the need to curtail the chiropodists' clinic work. This necessitated the closure of some 12 clinics and the patients concerned were transferred to others, but it must be noted that some of the clinics closed were held in very unsatisfactory premises bearing in mind that chiropody is a form of surgical operation.

County Chiropody Clinics

	1963	1964	1965	1966	1967
Number of chiropody clinics operating ..	63	96	126	134	122
Old Peoples Homes visited (Welfare & Private)	9	15	21	28	29
Treatments at Welfare Homes	397	888	1851	2615	2907
Treatments at Private Homes	101	200	737	611	806
Treatments to Schoolchildren	363	1542	916	1136	1598
Treatments to adults at clinics	17270	26530	38550	43824	50467
Domiciliary visits to give treatment	—	329	737	950	998
Total treatments provided	18131	29489	42791	49136	56776
Waiting List at 31st December	432	498	762	482	862
Chiropodial appliances fitted	—	—	—	—	595

Hospital Car journeys undertaken—6,692.

RETIREMENT CLINICS AND THE PAIGNTON SURVEY

The Paignton Survey

The Paignton Survey which was started in 1965 and was described in detail in the 1966 Annual Report continued during 1967.

Patients aged 50, 55, 60, 65 and 70 who were registered with Dr. J. F. Burdon of Paignton were offered an extremely detailed examination of their physical, mental and social state. Each patient was seen by a health visitor, nurse, D.C.C. medical officer and Dr. Burdon.

Useful information was obtained which was helpful in the planning of retirement clinics, viz.:

1. A great deal of treatable and unsuspected disease is present in the community.
2. The general procedure adopted at Paignton was satisfactory and should be used with modifications at retirement clinics.
3. Some of the tests and questionnaire section used at Paignton yielded a great deal of useful information while others were of little value.

A limited version of the Paignton Survey questionnaire and tests could, therefore, be used at the retirement clinics, increasing efficiency and without losing information.

Centres

Retirement clinics were started during 1967 at Ottery St. Mary in April and at Honiton and Tiverton in June.

Age Group

After consulting several authorities on the subject and also from the trends at Paignton, it was decided to start retirement clinics in the 65–70 year age group.

We realised that if we saw younger patients fewer illnesses would be diagnosed but those that were would have a greater chance of receiving successful treatment. If older patients were examined, more illness would be found but the chance of successful treatment would be less.

As it is impossible to offer this service to all age groups at present, the 65–70 group was chosen as a compromise.

Procedure

General practitioners in the three towns chosen compiled age/sex registers of their practices if they did not already possess them. The general practitioners then invited their patients aged 65–70 to participate.

If the patient accepted the invitation, he was given medical and social questionnaires to complete and told how to obtain a chest X-ray and given an appointment to attend a screening session.

At the screening session, he was interviewed by a health visitor and given tests by two specially trained local authority nurses.

He was finally examined by his general practitioner who arranged treatment for any condition discovered.

Acceptance

	<i>Honiton</i>	<i>Ottery St. Mary</i>	<i>Tiverton</i>
Attended	94	101	85
Refused	100	24	129

It is interesting that the highest proportion of acceptances is at Ottery St. Mary where there is a health centre. Honiton and Tiverton each have a local authority clinic with separate general practitioner surgeries.

Other factors may also be responsible for the differences such as the higher proportion of newcomers to Devon at Ottery St. Mary and the differences in social structure in the three towns.

The possible reasons for refusals are being investigated and it is hoped to improve the acceptance rate.

Findings

An early assessment of the value of these clinics was made after 75 patients had been examined. Further assessments will be made from time to time.

Of these 75 patients, 55 had some newly discovered disease which required treatment.

The average per patient of newly found diseases requiring treatment was 1.3. The total number of diseases was 209.

Of these some were minor conditions with a simple remedy but which nevertheless were worthwhile treating—examples of these were wax in the ears causing deafness or mild anaemia responding to treatment with iron.

Other conditions included diabetes, glaucoma, hypertension and uterine prolapse. The discovery of these and their treatment could well prevent considerable discomfort, disability or even premature death later.

The Future

The procedure is constantly under review and where possible will be altered as information accumulates, to provide greater acceptability and efficiency.

It is hoped to start retirement clinics in more centres as money permits.

PART V

Environmental Hygiene

Food and Milk

Water Supplies

Sewarage and Sewage Disposal

FOOD AND MILK

Food hygiene is supervised by district medical officers of health and the public health inspectors, but, with the exception of Torquay, sampling of food under the Food and Drugs Act, 1955 is undertaken by this department.

There are five sampling officers in the county, whose function it is to procure samples of any food which is sold for human consumption and they are supervised by the county health inspector. Food and Drugs Act samples, other than milk, are sent to the Public Analyst for examination, but the majority of milks are subjected to the gerber test in this department and only the suspicious samples are submitted to the Public Analyst.

During the year, 2315 formal and informal samples were taken. 125 milk and 835 other commodities were submitted to the Public Analyst and the remaining 1355 (all milks) were examined by the gerber test in the laboratory attached to this department.

The samples submitted to the Public Analyst represented a wide range of foodstuffs and medicines, including ice cream, sausages, spirits and various proprietary medicines, drugs and vitamin preparations.

The Public Analyst reported that of the 960 samples he received, 72 were either adulterated or gave rise to some other irregularity. 45 of the samples were of milk and 20 of these were ones in which the non-fatty solids and/or butter fat was below the normally accepted figure, but investigation in each case showed that the milk was being sold in the same condition as it came from the cow and that no offence under the Food and Drugs Act was being committed. The remaining 25 samples of milk were found to contain added water in varying amounts and three vendors were prosecuted.

The remaining 27 samples other than milk reported on by the Public Analyst included a crystal mint sweet containing a fragment of cotton wool, cheese containing partly burnt cigarette tobacco and cigarette paper, a tin of peas containing a green caterpillar, a steak and kidney pie which was contaminated by mould, uncooked puff pastry contaminated by mould, a packet of frozen peas found to contain a dead snail, clotted cream contaminated by mould, and also two meat pies and one sausage roll which were contaminated by mould, part of a sliced, wrapped loaf which contained a blue bottle fly, and another sliced, wrapped loaf bearing a growth of mould, a custard tart contaminated by mould; also a pork pie, Aspirin tablets containing 0.05 per cent of free salicylic acid in excess of the permitted maximum and supplied in an incorrectly labelled container, two pork pies and a pasty which had suffered spoilage by a growth of mould, a piece of rock confectionery which contained a piece of metal, chocolate wafer biscuits containing particles of a metallic alloy, a further sample of clotted cream, and curry powder contaminated by mould, 'anti-pain' tablets supplied in an incorrectly labelled container, a packet of potato crisps which contained a cadmium plated steel hexagonal nut and sedative cough linctus containing yeast cells in suspension. Six of these cases resulted in prosecution and similar action was recommended in other cases; warning letters were sent in six other instances.

The sampling officers take their samples with very considerable care and selectivity. Apart from the help given in this department, they are assisted and advised in their choice of samples by consultation with the Public Analyst and by a close study of the reports issued by the Public Analysts of other counties and published accounts of the legal action taken by other Food and Drugs authorities.

All complaints of alleged infringements of the principal Acts or the many Regulations, etc. made under it are very carefully examined. The co-operation of the public and of other local authorities is welcomed and I hope that this assistance will increase in the future.

Brucella Abortus

Towards the end of 1963, a sampling programme was initiated to determine the degree of infection by this organism in the milk sold for human consumption, and this sampling has continued ever since. The results during the year under review were as follows:—

Total number of samples submitted	.. .. .	1,345
Number positive on Ring Test but negative on culture	..	178
Number positive on culture	.. .. .	46

Immediately a positive culture was known, the medical officer of health for the district and the divisional veterinary officer was informed and steps were taken to prohibit the sale of the infected milk and to trace the offending animal or animals. Normally, two consecutive negative results are required before the raw milk is allowed to be consumed again and the number of samples taken is increased.

Biological Examination of Milk for the Presence of Tuberculosis

During the year a total of 1,103 samples was submitted, special attention being paid to milk to be sold unpasteurised. There were no positive results, and there have been none since the year 1959.

The Milk (Special Designation) Regulations, 1963

These Regulations, which came into force on September 29th, 1963 gave to the County Council the duty of licensing every dealer in designated milk; this work had previously been carried out by the public health departments of 47 district councils. The task of supervision and control by one authority was, therefore, a formidable one.

It has meant the annual inspection and general approval of the premises and milk handling facilities of 858 dealers and a comprehensive sampling programme is now in being.

During the year the following samples were submitted:—

<i>Pasteurised</i>	<i>TOTAL</i>	<i>Number failing Phosphatase test</i>
	952	nil
<i>Untreated</i>	<i>TOTAL</i>	<i>Number failing Methylene Blue test</i>
	473	30
<i>Sterilised</i>	<i>TOTAL</i>	<i>Number failing Turbidity test</i>
	21	nil

When a sample fails to pass the prescribed test, an immediate inspection of the dealer's premises is made and repeat samples are taken where necessary. If it is thought that the failure, in the case of untreated milk, is the fault of the producer, the Ministry of Agriculture, Fisheries and Food's Divisional Milk Officer is informed.

The Milk (Special Designation) (Pasteurised and Sterilised Milk) Regulations, 1949

The County Council issued licences to the six pasteurising plant operators remaining in the county but this number dropped to four during the course of the year; a very careful watch is kept on both the plants and the processed milk. This involves regular inspections and samples are submitted for laboratory examination at very frequent intervals. 163 samples were taken from these plants during the year, all of which passed the phosphatase test.

Additional checks on the quality of the processed milk are afforded by the routine sampling of milk supplied to the schools in the county, as a very large proportion of school milk is derived from these plants.

SCHOOLS

Milk in Schools Scheme

The tendering and three-year contract system of supplying the schools with milk which commenced in 1955 has worked with great success as far as this department is concerned. 511 schools in the county received milk, including private schools; only 5 of this number are receiving raw milk, the remainder being supplied with pasteurised milk. Every effort was made to find a supply of pasteurised milk for the 5 schools in question, but largely on the grounds of distance and excessive cost it proved impossible to arrange.

School Swimming Pools

I welcome the rapid progress which is now being made with the provision of swimming pools for schools throughout the county. Most of them are of the learner type but a few, particularly in the larger secondary modern schools, are large enough for the advanced swimmer. At the end of the year 155 pools had been completed and more are contemplated for the following summer.

The Education Committee are prepared to consider grants of £250 for primary school pools and £500 for secondary schools, or half the cost — whichever is the smaller. In most instances the Head Teacher has been able to raise the balance from voluntary sources, e.g. parent-teacher organisations.

This rapid increase in the number of school swimming pools has meant a considerable extension of the work of the department. The sampling officers visit every school once a week and obtain a sample of water for bacteriological examination. If this sample is the subject of an adverse report, the County Health Inspector visits the school immediately and offers the appropriate advice. The all-important consideration is to maintain a satisfactory level of residual chlorine in the pool at times of peak load, and our experience has been that this can only be achieved in the hand-dosed pool by continual checking and the repeated use of booster doses of hypochlorite solution throughout the day. This supervision will undoubtedly occupy a certain amount of the time of an already busy Head Teacher, but it is a responsibility which cannot be shirked if the pool is to remain an asset rather than a danger to the health of the children.

On a number of occasions the samples from a minority of pools (which, of necessity, have to be collected before lunch) gave unsatisfactory bacteriological results and if samples were to have been taken in the afternoon when the peak bathing load, allied to higher water temperature, was exerting its full effect on the available chlorine, then undoubtedly the picture would have been

worse. Spot checks on the chlorine residual in the pools were frequently carried out by the County Health Inspector and these only confirmed the truth of this statement.

It is clear that some Head Teachers do not realise how rapidly chlorine can be dissipated from pool water under the influence of warmth and bright sunshine, even when the pool is being used, as each child contributes organic impurities which lock up and neutralise chlorine which would otherwise be available for killing germs.

My advice to Head Teachers is that it is a mistake to economise with chlorine; if they are hand-dosing, then the initial application of the day may well require hypochlorite solution at the rate of 3 to 5 pints per 10,000 gallons of pool water, with booster doses, whenever necessary, throughout the day of $1\frac{1}{2}$ to 2 pints; these figures are given as a guide and will vary under individual circumstances. Testing need not be a time-consuming operation: the D.P.D. test can be carried out in ten seconds and there is no excuse for children using a pool without a chlorine residual of at least 1.0 part per million.

The above remarks apply basically to hand-dosed swimming pools, but these are now in the minority. However, it was found that even where a pool possessed an automatic filtration and chlorination system, that the Head Teacher's troubles were not over, as in many instances some small fault had arisen which had put the equipment temporarily out of operation. To overcome this difficulty, the County Council came to an arrangement with a specialist firm to overhaul and maintain all such filtration and chlorination plants, and to visit any school immediately a breakdown was reported. I have no doubt that this will prove of enormous value to all concerned.

Milk

The County Dairy Husbandry Advisor of the Ministry of Agriculture, Fisheries and Food informs me that, at the end of 1967, there were 7,123 registered milk producers, a decline of 209 on the previous year. 597 licences permitting the sale of "Untreated" milk by producer/retailers were in operation, a decline of 24 during the year.

Animal Health Division — Devon

The Divisional Veterinary Officer of the Ministry of Agriculture, Fisheries and Food reports as follows: "Until the middle of October, 1967 was both a normal and satisfactory year from a disease point of view. Since that date, however, although Foot and Mouth Disease did not affect the County, indirect repercussions were felt owing to the fact that all staff in turn were sent on Detached Duty.

The cattle populations in the County has risen by 10,600 to 550,799 while sheep, pigs and poultry all show a decrease.

During the year 273,565 cattle have been Tuberculin Tested. 48 reactors were revealed which gives a percentage of 0.017. This compares with 0.03% in 1966. The 48 reactors revealed in 1967 is a decrease as compared to 1966 when 94 came to light.

With regard to Swine Fever, no cases were confirmed during the year under review, there was only one reported case. In 1967, 117 cases of anthrax were reported and suspected, of which 13 were confirmed. This compares with 84 and 2 respectively for 1966.

One case of Fowl Pest was reported during the year under review but was not confirmed. No reported cases were reported at Divisional Office during 1966.

With regard to Foot and Mouth Disease, although disease was not confirmed in this County in 1967, 2 reported cases and 30 consultation cases were dealt with, all of which were negative.

Poultry Health Scheme

This scheme has now been running for twelve months and has attracted 67 flocks. During the year 87,363 birds were blood tested.

It is gratifying to note that the **Free Calfhood Vaccination Service** has again been very satisfactory during 1967. 7,780 cattle owners are participating. It should be remembered that the vaccination period was changed from 4—8 months down to 3—6 months of age. During 1967, 59,517 doses have been used, which compared with 48,479 in 1966, 41,420 in 1965 and 31,496 in 1964.

There are 24 markets operating in this County, all of which are inspected as and when work permits.

There are 75 slaughterhouses and all are inspected at frequent intervals.

I would like to record my thanks to Dr. Lyons, his Medical Officers of Health and the Public Health Department for their excellent co-operation."

WATER SUPPLIES

Water Boards in the county have all been active during the year, and all have substantial schemes either in course of construction or awaiting the consent of the Ministry of Housing and Local Government. This progress is emphasised by the amount of precept which each Board makes on the county council.

Comparative figures are as follows:

	1965/66 <i>Actual Cost</i>	1966/67 <i>Actual Cost</i>	1967/68 <i>Probable Cost</i>
North Devon Water Board	£240,523	£194,125	£208,400
South West Devon Water Board	£44,802	£45,693	£45,000
East Devon Water Board	£30,604	£30,852	£28,000

The North Devon Water Board now covers an area of 1,664 square miles; approximately 1,275 miles of mains have been laid and the average quantity of water supplied is over 9.5 million gallons per day. The total capital expenditure incurred by the Board up to 31st March, 1967 was £7,408,055.

The South West Devon Water Board was formed under Ministerial Order to operate from 1st October, 1963, and it took over the water undertakings of the South Devon Water Board and of the Boroughs of Torquay and Totnes; the Urban Districts of Ashburton, Brixham, Buckfastleigh, Dawlish, Paignton and Teignmouth, the Rural District of Newton Abbot and part of the Rural District of St. Thomas lying to the south of the River Exe. The statutory area is approximately 500 square miles and the total amount of water produced in 1967 was 4,514 million gallons. The total capital expenditure to the 31st March, 1967 was £6,885,576; of this, £1,007,525 has been incurred by the Board and £5,878,051 represents the book value of assets transferred under the Order. The outstanding debt at the 31st March, 1967 was £4,268,754. Up to the 31st December, 1967 the new Board had laid 133 miles of mains.

The East Devon Water Board was reconstituted on the 1st October, 1964 and now comprises the authorities of the original Board, together with the County Borough of Exeter, the urban districts of Budleigh Salterton, Exmouth, Seaton and Sidmouth, the whole of the St. Thomas Rural District area east of the River Exe and the District Water Undertaking of the Colyton Feoffees. The total capital expenditure of the authorities included in the Board amounted to £4,602,744 at the 31st March, 1967. Of this figure £1,960,825 was incurred by the Board itself and £2,641,919 represented the debt of transferred undertakings.

During the year 1967 the Board completed the drilling and test pumping of the seven boreholes mentioned in the last report. One borehole known as the Fortescue borehole within the parish of Netherex to the north of Exeter was successful, and so were two others in the eastern part of the Board's area at Ottery St. Mary and Dotton respectively. Two other boreholes at Dotton produced a strong iron content in the water, but it is hoped to remove this extraneous matter by treatment, and to bring the boreholes into operation for public supply purposes. Two other boreholes in the parishes to the north of Exeter proved to be unsuccessful, and have had to be abandoned. During 1967 the Board completed negotiations for the sinking of a further borehole at Harpford. The reliable yield of the Board's sources will be increased by 1,500,000 gallons per day when the successful boreholes have been brought into operation for public supply purposes. Licences have been obtained for them, but Orders are still required from the Minister of Housing and Local Government under the Water Acts.

During the year 1966/67 the Board spent a total of £217,896.

During the year grants under the Rural Water Supplies Acts were agreed to in principle on the following schemes:

<i>Local Authority</i>	<i>Parishes or Areas Affected</i>	<i>Estimated Cost £</i>
South-West Devon Water Board	Ashwell & Bishopsteignton	16,000
	Compass Cove, Dartmouth	1,150
	Coombepark, Ashprington	4,600
	Haldon Prison Camp	7,700
	Lower Dawlish	1,500
	Poole Cross/Torbryan	5,440
	South Allington, Chivelstone	1,100
	South Efford House Area, Aveton Gifford	1,100
	Sutton, South Milton	1,700
	Ticketwood, West Alvington	600
	Widecombe-in-the-Moor, Dunstone and Poundsgate	50,000

Sewerage and Sewage Disposal

The following schemes submitted to the County Council for financial assistance were examined by the County Health Inspector and recommendations in each case were made to the Appointments and General Purposes Sub-Committee:

<i>Local Authority</i>	<i>Parishes or Areas Affected</i>	<i>Estimated Cost £</i>
Barnstaple B.C.		595,000
Barnstaple R.D.C.	Bishopstawton, Landkey and Swimbridge	229,259
Bideford B. and Northam U.D.C.		827,133
Crediton R.D.C.		1,489
Honiton R.D.C.	Feniton and Sidmouth Junction	58,200
Kingsbridge R.D.C.	Bigbury/Challaborough	113,000
	Charleton	32,050
	Chillington and Frogmore	97,300
Lynton U.D.C.	Barbrook	39,396
Plympton R.D.C.	Bickleigh	6,141
	Down Thomas, Heybrook Bay and H.M.S. Cambridge	59,000
	Ivybridge	387,000
	Wembury	313,000
Seaton U.D.C.		197,000
South Molton R.D.C.	Meshaw	7,798
Tavistock R.D.C.	Lifton and Tinhay	31,550
Tiverton R.D.C.	Cullompton	415,000
	Shillingford	17,300
	Ashill	43,000
	Huntsham	16,940
Torrington R.D.C.	Dolton	57,500

PART VI

MISCELLANEOUS SERVICES

Capital Building Programme

Health Centres

Clinics

Ambulance Stations

Junior Training Centres

Hostel Accommodation—Children

Adult Training Centres

Hostel Accommodation—Adults

Accommodation For District Nurse/Midwives

Course on General Practice Administration

Economics and the Health Service

CAPITAL BUILDING PROGRAMME

HEALTH CENTRES

In 1963 in Buckfastleigh, the birth took place of the health centre concept as a means for providing accommodation for general practitioners and local health authority services in a predominantly rural area. Named "The Timms Centre" after the Chairman of the Health Committee, it was opened in 1965.

Since then, health centres have also been provided at Ottery St. Mary, Okehampton, Lynton, Ipplepen, Ilfracombe and Seaton. These have provided accommodation for a total of 19 general practitioners as well as the usual health authority field staff and school health personnel together with certain facilities for the staff of the Children's, Education and Welfare Departments and in one instance, the registrar of births, marriages and deaths.

Health Centres Opened in 1967

Ipplepen

This centre although used by his two partners is provided mainly for one general practitioner. Although a small building, it provides adequately for the doctor and local authority services and is the first of its kind to have a purpose-built integral dispensary. The nearest pharmaceutical chemist is 4 miles away in Newton Abbot.

Ilfracombe

Accommodation at this centre is provided for both partnerships each of two doctors. The local authority accommodation includes a dental suite.

Seaton

The centre provides accommodation for one of the town's partnerships of three doctors and has been designed in such a way that a future extension could be added should the second practice wish to participate. It is also possible that the trustees of the now defunct cottage hospital trust fund may wish to donate money to provide additional accommodation, such as treatment and common rooms.

HEALTH CENTRES UNDER CONSTRUCTION

31st December, 1967

Ashburton

Likely completion date — July 1968.

Budleigh Salterton

Likely completion date — March 1968.

Bovey Tracey

Likely completion date — April 1968.

This building was designed to be erected in two stages. The first comprised a local authority clinic and the second consisted of accommodation for the two doctors which at the time of planning was not required. At the time of

acceptance of the tender for the clinic the doctor's circumstances changed and they found themselves in urgent need of new surgery accommodation. The very highest tribute must be paid to the Ministry of Health, the Executive Council, the County Architect and others as it was found possible within a very few weeks to obtain full approval to the second stage so that the enlarged building could proceed with the minimum of delay and cost. From conception to completion will probably amount to only nine months which may well make it the fastest health centre yet !

Cullompton

Likely completion date — September 1968.

Great Torrington

Likely completion date — March 1968.

Kingsteignton

Likely completion date — March 1968.

South Molton

Likely completion date — September 1968.

Colyton

Likely completion date — July 1968.

Combe Martin

Likely completion date — July 1968.

All the necessary approvals had also been obtained for the erection of health centres at Northam, Ivybridge, Holsworthy and Sidmouth and it is to be hoped that the financial situation will not prevent tenders being invited in the early part of the new year.

Plans had also been approved for a centre at Yealmpton but difficulty in acquiring the site was delaying the project.

Future Programme

By the close of the year, the Ministry of Health had approved plans for health centres at Dawlish, Salcombe, Chagford, Moretonhampstead and Chudleigh, but the financial crisis has resulted in uncertainty over starting dates.

During the year a site for a centre was purchased at Totnes.

Two sites in Torquay owned by the County Council will pass to the new Torbay County Borough on April 1st 1968.

Work in connection with site acquisition continued at Kingsbridge, Yelverton, Exmouth, Bideford, Barnstaple, Honiton, Axminster and Dartmouth.

CLINICS

Certain of the buildings mentioned under the health centres heading may eventually be built as clinics if final agreement with the general practitioners does not materialise. In all cases, however, the building will be designed so that a future extension can be added easily should the needs of the doctors change.

There is still a very urgent need to replace much of the existing hired clinic accommodation where condition are deplorable. Some of the conditions may again be listed as follows:

1. Several premises are very dirty and, because of age and dilapidations, impossible to keep clean.
2. Water closets often out of action and frozen in cold weather.
3. Buildings so poorly heated that babies and toddlers cannot be examined except in warm weather.
4. Complete lack of privacy and sound-proofing so that no matters of a confidential nature can be discussed.
5. Dangerous stairs and steps which are hazardous to mothers carrying babies, elderly persons, expectant mothers and toddlers.
6. Inadequate means to provide hot water.
7. Cramped conditions. In one instance the doctor has to sit in a wash-room immediately outside the lavatory which is used by the public attending the clinic.
8. In one place which is also used as a club, the clinic takes place in a bar where evidence of the previous night's revelry may still be found.

The only new clinic building in 1967 took place at Tiverton where an urgently needed hutted extension was provided to the existing building.

Temporary accommodation was found in Tavistock and Plympton to house staff who needed to be based in this area after the transfer of Plympton and Plymstock to the Plymouth County Borough. Temporary accommodation was also found in Totnes and Teignmouth but by the end of the year notice to leave had been given in the latter instance so that further accommodation was being sought.

At Axminster, negotiations were proceeding with a view to hiring temporary accommodation from the Rural District Council.

Kingskerswell

For another year, no progress could be made in the development of this site except to demolish the derelict house which by now had become in a dangerous condition.

AMBULANCE STATIONS

No ambulance stations were under construction during 1967. At Holsworthy, plans were approved by the County Council and the Ministry of Health for a small station to be built as part of the health centre scheme and it is to be hoped that work will commence on this in the early part of 1968.

JUNIOR TRAINING CENTRES

These have been provided since the war at:

	<i>Day Pupil Places</i>	<i>Residential Places</i>	<i>Total No. of Places</i>
Barnstaple, Abbeyfield	32	28	60
Dawlish, Oaklands Park	11	43	54
Paignton, Mayfield and	48	—	48
Mayfield S.C. Unit	14	—	14
Plymstock, Downham	39	23	62
Total	144	94	238

Paignton, Mayfield

Building work was completed during the year to provide an additional 12 places together with a manual instruction room and a special care unit. The cost of the latter was generously donated by the National Spastics Society.

Plymstock, Downham

Building work was completed during the year to provide an additional 12 places, a kitchen, a new dining hall and a manual instruction room. This centre, although now within the boundaries of the County Borough of Plymouth remains under the control of the County Council. In order to provide further extensions at this centre, negotiations had almost been finalised with the Plympton Rural District Council to acquire more land at the back of the present building. With the transfer of the area to the Plymouth County Borough negotiations had to be re-commenced and had not been completed by the end of the year although a favourable outcome is anticipated.

HOSTEL ACCOMMODATION FOR CHILDREN

No additional places were provided in 1967.

ADULT TRAINING CENTRES

Barnstaple

A purpose-built 120 place centre completed early 1966.

Exmouth (William Doyle)

A 90 place centre completed in December 1966.

Paignton (Hollacombe)

Formerly built as a 60 place centre, work commenced to double to size of the building and by the end of the year, the extension had almost been completed.

Tavistock

During the year work commenced on the building of a new 50 place centre, which the health committee agreed to name the Molly Owen Centre after the present chairman of the adult health sub-committee and vice-chairman of the health committee.

Axminster

Work commenced during the year on the building of a new 60 place centre which is to be named after a former chairman of the health committee, the late Mrs. Juanita Phillips.

Holsworthy

The former territorial army hall was purchased in order to provide temporary accommodation for an adult training centre pending the erection of the new purpose-built centre. In order to help the export drive and to provide employment in this development area, the building has been leased to a local industrialist pending the completion of his new factory. The industrialist in his turn has promised to help us with the finding of work for the centre and whenever possible, finding suitable employment in his factory for handicapped people.

Crediton

The use of the present building as a 50 place centre was granted for a further seven years. In the meantime, negotiations for the new site continued into the fifth year !

HOSTEL ACCOMMODATION FOR ADULTS

Marldon (Occombe House)

A new sewage disposal system was completed in 1967.

Barnstaple (Hawley)

This building, apart from urgently needed staff accommodation, was completed in 1966.

SITES FOR ADULT TRAINING CENTRES AND HOSTELS

By the end of the year sites had been acquired as follows:

1. **Kingsteignton** — for a new 120 place adult training centre and 26 place hostel. The training centre which it is proposed to erect on this site will cover a population of approx. 100,000 including the towns of Ashburton, Buckfastleigh, Dawlish, Newton Abbot, Teignmouth, Totnes and the surrounding area.
2. **Kingsbridge** — for a 50 place adult training centre and 30 place hostel.
3. **Holsworthy** — for a 50 place adult training centre and 30 place hostel.

Sheltered Workshop — Barnstaple

In December 1967 tenders were invited for the new sheltered workshop to replace the pre-fabricated building which had deteriorated still more during the past twelve months.

ACCOMMODATION FOR DISTRICT NURSE/MIDWIVES

Building construction was commenced or completed on housing units as follows:

Bampton
Winkleigh
Seaton (2 Flats)
Axminster (2 Flats)

The following housing units were purchased:

Crediton
Cullompton

COURSE ON GENERAL PRACTICE ADMINISTRATION

When a general practitioner moves into a health centre he often changes his methods.

For example, many doctors start an appointment system for the first time. They delegate more of the non-medical aspects of their work and make increasing use of secretarial staff and paramedical workers such as nurses, health visitors and social workers in mental health. The doctor then has more time to devote to the work that only he can do, and he can offer more to his patients in the way of preventive services which previously he may not have had time for.

In order to assist doctors who were considering moving into a health centre or who had already done so, a weekend course on general practice administration was held at County Hall on 14th and 15th October. It was organised by the health department through the postgraduate medical institute.

Forty-five general practitioners attended.

The speakers, who are international authorities on their subjects, included Dr. G. S. Adams on "Appointment Systems," Dr. R. J. F. Pinsent on "Records in General Practice," Dr. T. S. Eimerl on "Morbidity Studies" and Dr. J. Fry on "The Delegation of work and use of Paramedical Workers."

Dr. R. H. Glendinning spoke about working from St. George's Health Centre, Bristol, and Dr. Parken spoke about the Devon Health Centres. Devon general practitioner speakers were Dr. G. H. Gibbons, Dr. J. H. Bradshaw-Smith and Dr. M. S. Warwick.

Other lively contributions were made by those who attended the course.

The following Paper has been prepared by DR. D. S. PARKEN.

ECONOMICS AND THE HEALTH SERVICE

Perhaps an economic crisis is an appropriate time to look at some financial aspects of the National Health Service, and to consider how future development might obtain the best value for money.

Criticism of high cost is sometimes aimed at the National Health Service, but according to the Office of Health Economics, this country is spending at least one per cent less of its national income on health than many other advanced countries.

But there are problems because the National Health Service is split into three divisions—hospitals; the family doctor, dentist and pharmaceutical services; local health authority services.

Local authorities themselves ran several types of hospitals until the National Health Service Act was implemented in 1948. This relieved them of hospitals and an enormous annual outlay, but gave them instead the job of developing alternative community services, which would ultimately reduce the workload and expenditure of hospitals.

So if the local ratepayer ever feels he is indirectly helping Government-financed hospitals, he must not forget that the burden of running hospitals was lifted from him so that he could do this.

That apart, local authority services must be developed in harmony with the others, and overall there must be the best and most economic use of available finance and scarce manpower resources.

This is how Devon Health Committee services fit in with the hospitals and practitioner services:

Midwifery

The present hospital policy places increasing emphasis upon in-patient delivery and early discharge of mother and baby often 24—48 hours later. The planning of new maternity units takes this policy into account and results in a much quicker turn round of patients and the need to provide many fewer beds with reduced capital and running costs. The local authority midwife will thus have fewer home deliveries but will spend an increasing proportion of her time giving ante-natal and mothercraft teaching and nursing the mother and baby at home after early discharge, whilst the home help service will need to provide essential help in the domestic field. As the total number of practising midwives is not increasing, a local authority midwife in future may be called upon to perform duties in the hospital units and a Bill is at present being considered by Parliament to make this legally possible. The midwife carries out all her duties from the earliest ante-natal stage in the closest possible way with the patient's doctor and this is greatly facilitated when both use the same health centre premises. There is the constant need to review the areas covered by the midwives and work in hospital units may lead to a more radical change. It may be possible to provide the service at a slightly lowered cost to the local authority although a really significant reduction is to be doubted.

District Nursing

Many midwives are also district nurses, and they work closely with family doctors in the treatment and care of sick, elderly and handicapped people. Here again, the health centre, which can be used as a base for the health visitor, home help organiser and other social workers, is the key link between the doctors and the county council staff in providing supporting services which save some patients from going into hospital.

The size of a hospital depends partly on the number of beds and these in turn depend amongst other things, upon the patients' length of stay. Investigations have shown that the average stay in hospital for a wide range of common conditions varies a little from region to region in this country but when related to hospitals in the United States and certain continental countries, we find that the time spent as an in-patient is often far greater in Britain. There is no suggestion that the patient is any the worse for his earlier discharge in these other countries and in fact the contrary may be true. The difference is thus between providing costly in-patient facilities or adequate domiciliary services which are considerably less expensive to provide. This problem could also be discussed in respect to alleviating the present shortage of hospital beds but as there are so many other factors involved, it is perhaps correct to consider this beyond the scope of these notes.

Health Visiting

The health visitor is a trained nurse, health educator and a medico-social worker. Working with families, children, handicapped and elderly people, she aims to promote health, prevent illness, spot early signs of distress, help with social problems and to ensure that certain medical advice is understood.

The health visitor has a special part in aiding the small percentage of families who have serious or complex problems.

The very nature of her work demands the closest contact with family doctors and her county council colleagues—so once again proving the value of the health centre link.

Health and Welfare of Young Children

Parents face an enormous range of problems connected with their children's physical and mental health and development. The aim of the health staff is to help parents deal with them.

Children are examined, and parents advised on any problems with special emphasis on detecting abnormal development, aiming to initiate all possible remedial measures as early in the child's life as possible.

There are vaccination and immunisation sessions against smallpox, diphtheria, whooping cough, tetanus, poliomyelitis and next year, measles. They play a large part in preventing diseases.

Parents' clubs meet at clinics and health centres for lectures, films and discussions on various health matters.

In short, early diagnosis, early treatment and the long term effects of health education are planned to ensure a healthy start in life.

Again, the financial value cannot be estimated. But consider, as an example, a deaf child who is treated while he is still young enough to learn to speak and spared having to live in the world of a deaf mute.

Consider the costs which have been saved on the closing of infectious diseases hospitals—or the cost of treatment and equipment for a person crippled by polio, which has been almost entirely eliminated in the past few years.

Consider the beneficial effects of all other early diagnosis.

Consider how health education is gradually making its contribution.

School Health Service

The School Health Service which is a responsibility of the Education Committee is not part of the National Health Service, but is mentioned in these notes as in many ways, it is an extension of child welfare work. From the physical and mental health aspects, its aim is to help children to benefit as fully as possible from the education provided.

Routine medical examinations are performed and appropriate recommendations are made for treatment and when necessary, for the provision of special educational facilities for the more severely handicapped.

Hearing assessment clinics are of special importance and call for close co-operation with the child's doctor, the ear, nose and throat consultant, the educational psychologist, the audiometrician and the teacher of the deaf.

Children with specific defects of speech can be treated by the speech therapist at the health centre/clinic.

The child guidance team of children's psychiatrist, educational psychologist, psychiatric social worker and psychotherapist assist a considerable number of children and their parents with the object of promoting mental health.

There is a special link with the youth employment officer at school leaving age so that he can be made aware of occupations which should not be offered to certain children, e.g. epileptic, asthmatic, colour blind, etc.

To the other immunological processes is added B.C.G. vaccination against tuberculosis.

Special attention is paid to vision and children whose sight is defective are referred to specialists employed by the Regional Hospital Board who test and prescribe for them at the health centres and clinics.

The above is but the briefest outline of a wide and comprehensive service. Many of the local authority staff who are involved are also those who work on behalf of the Health Committee or elsewhere within the National Health Service and likewise need to effect the closest liaison with general practitioners and with many other local authority personnel, especially the education welfare officers (who are now being based in the health centres), child care officers, welfare officers and others.

The health centres again provide the means by which this liaison can be effected in the most efficient manner. The financial implications are only too obvious and follow the lines already discussed under the previous heading.

Occupational Therapy

The occupational therapist is a medical ancillary who has an important role in rehabilitating physically disabled, mentally handicapped and elderly people. She provides individually planned aids and gadgets to the disabled, advises the County Welfare Department on any adaptations necessary in the home and works with small groups of clients in the rehabilitation units attached to the training centres for handicapped adults.

Through her skills, many people receiving social security benefits have been helped back to full-time employment and have successfully overcome their handicap. Similarly, this applies to the housewife who although perhaps confined to a wheelchair can nevertheless now undertake many household duties. Even when success such as this cannot be achieved the patient can enjoy a fuller life at home, being less of a burden to the family and consequently not in need of special welfare accommodation or hospitalisation.

The occupational therapist works especially closely with the general practitioner with whom she discusses the needs of the patient and with the district nurse and other colleagues. The overall financial implications of this service are thus apparent and again are seen the communication advantages afforded by the health centre.

Mental Health

The Health Committee is responsible for:

1. Social workers in mental health.
2. Junior and adult training centres.
3. Junior and adult hostels.

Junior training centres provide for the training and "education" of the young sub-normal and in this respect can be considered as providing services comparable to those in schools. Additionally, by the relief they provide for parents, they are able to prevent many of these children having to be admitted to very much more costly hospital accommodation.

Adult training centres provide training facilities and employment under sheltered conditions for handicapped people (including some physically dis-

abled) and although not expected to show "profits" in their accounts have nevertheless important economic aspects as follows:

1. Through training and the social aspects of the centres at least 80% of the trainees can continued to live in the community and so do not make demands on the hospital services.
2. Over the past three years, 93 trainees all of whom had been in receipt of "benefit" (many for a considerable number of years) were found full-time employment as a direct result of training, etc., given at the centre.

In spite of the policy of discharging to outside employment as many of the best workers as possible, the output value per capita has risen from £23.9 in 1964 to £94.4 in 1967, although of course, the cost of running the centres has increased during the same period.

When a person is accommodated in a hostel, the cost to the community is considerable—£491 a year. But a hospital bed costs £603 a year—and the real difference is actually greater because the county council's figures unlike those of the hospital, include interest charges on the loan for the building.

The Mental Health Act 1959 and later Ministry pronouncements envisage that psychiatric hospitals for the mentally sub-normal should be reduced in size to cater only for the needs of those who cannot live in the outside community. The economic importance of this is thus only too obvious when it is realised that such hospitals in Devon have a planned reduction of 600 beds. In the long term, this will mean that many more people who would formerly have occupied hospital beds will now continued to live in their own homes, in lodgings or in hostels but will require support from social workers in mental health.

The Health Committee also envisages half-way homes for mentally ill patients not needing hospital treatment but requiring rehabilitation.

Much existing hospital accommodation for the mentally ill which at present consists of out-of-date buildings will be scrapped and new smaller units will take their place—a total planned reduction of more than 1,000 beds. This is made possible by new treatment methods but inevitably will greatly increase the work load of social workers in mental health.

The importance of adequate planning such as the County Council's ten-year plan in association with the hospital authorities is apparent and again it must be a matter of concern that we provide not only a first-class service but one that the nation can afford. The provision of a community service along these lines will be overall much less costly, but at the same time represents a major transfer of responsibilities from hospital to local authority.

Although the local authority's capital building programme will be involved in the provision of half-way homes, the greatest repercussions will be upon the social workers in mental health who are deeply involved in the community care programme with family doctors and consultant psychiatrists.

Social Workers in Mental Health

Basically, the aims of the social workers in mental health may be summarised:

1. To prevent mental illness from starting.
2. To provide early help before an illness becomes more serious.
3. To provide information to general practitioners and consultant psychiatrists and others, and to assist them in their medical and social assessment of the patient's conditions and treatment needs.
4. To provide for after-care needs in order to assist rehabilitation.
5. In their capacity as mental welfare officers they have the statutory responsibility to formulate their own opinion as to the need for compul-

sory admission and must have regard to all the circumstances before making application for observation or treatment in a psychiatric hospital.

Their true value is not only in easing immediate distress but in helping to prevent mental illness in this and future generations.

While the Health Committee is aiming to have two family case-workers in each of the four areas of the County to give more time to individuals and families, after-care work now often stops abruptly or never even starts. Social workers with more than a hundred cases each are dealing almost entirely with emergencies.

This is a vicious circle. Because preventive work is either inadequate or absent, the legacy of inherited mental illness has grown, and obviously, it will be inherited by future generations unless preventive work is effective. Even now, social workers often deal with two or three generations in the same family.

This situation must give cause for serious concern, especially when it is remembered that half our hospital beds are occupied by mentally disturbed people, and one-quarter of the patients treated by family doctors are emotionally disturbed rather than physically ill. Concern is felt not only at the human misery and suffering involved but also because of the staggering financial implications of inadequately co-ordinated development of local authority and hospital services. In the meantime, this high rate of sickness is having an adverse effect upon national productivity.

The advent of the health centre is again proving of inestimable value in facilitating the process of communication between the social worker and the doctor and other colleagues. A start has also been made by a psychiatrist who now conducts sessions in certain health centres where he is able to discuss various problems with those most closely involved, viz. the doctor, social worker, training centre manager and hostel warden.

Chiropody

Much has already been said about the value of the chiropody service, which literally keeps old and handicapped people on their feet, more active—and out of residential accommodation. The health centre, again, is a good base for the chiropodist because it enables him to increase his output and offers better and surgically safer facilities than many of the premises hired for sessions.

Home Help Service

In helping the sick, elderly, handicapped or expectant mothers to be cared for at home, the home help service is another means of easing pressure on places in hospitals and old people's homes. In other instances, families may receive help and to be kept together under various circumstances, e.g. the illness or death of the mother.

Most requests for the home help come from the family doctor, the district nurse/midwife, the health visitor, the hospital or direct from the individual. Precise financial savings are difficult to equate, but are obviously considerable—and clearly the service is the more efficient if the home help organiser is based at a health centre.

The Elderly

It has been the cornerstone of national policy to maintain that elderly people should have the facilities to live in their own homes for as long as possible. The great majority wish this so that they can enjoy privacy, follow their own pursuits, be surrounded by their own possessions and memories which in them-

selves provide some measure of stimulus to lead an active life. Their own environment provides the familiar street scene where they can pass the time of day with well known friends and acquaintances.

The alternatives to this consist of:

1. Re-housing in specially designed units preferably with a warden service and call bell system (the County Welfare Committee is responsible for the employment of the warden and the district councils for providing the housing units).
2. Admission to an old person's home (which is also the responsibility of the Welfare Committee).
3. Admission to hospital.

Although precise figures are not available, it is accepted by most authorities that to provide special services for the elderly and to their families in order that they may continue to live at home is generally less expensive than other measures and considerably less than admission to a home or hospital and is usually more acceptable to the person concerned. In particular instances, however, the amount of help that might be required is relatively expensive especially when travelling is necessary to reach clients living in remote country areas. The economic advantages then disappear and the humanitarian aspect has to be balanced against the cost and manpower factors.

In this somewhat controversial book "*The Last Refuge*," Professor Peter Townsend, a sociologist, after describing in detail his survey of old people's homes in England and Wales, came to the conclusion that as existing today and projected in the future, this form of provision is already outmoded. His argument is broadly based on the premise that given adequate domiciliary services it would be possible to keep many more elderly people living happily in their own homes until a later age. Special housing facilities with warden schemes, again supported by domiciliary services, would aid those who become unable to live at home and later, when the elderly person becomes too frail or ill for such provision he would come into the hospital sphere for treatment and/or care and attention.

It is acknowledged that this represents only a rough analysis of Townsend's detailed work on a complex subject but as one who is not directly responsible for all these services, I must add that I can by no means support many of his suggestions. I feel, however, that the importance of what he is saying is to draw our attention to the need to investigate the services for the elderly as a whole in order that we may make the best possible use of our resources and in a way which is most acceptable to the recipients. I would advocate that any investigation should be in depth not only in urban but also in rural areas and should aim to give us greater knowledge both as regards needs and the most acceptable and financially advantageous ways of providing these. Although the ideal may be economically unobtainable, research could be helpful in as much as it might suggest a reasonable balance between the humanitarian and economic aspects of the problem.

It is realised that these are long-term suggestions and that both health and welfare departments have to meet immediate needs but nevertheless research is itself a lengthy process and it is believed that a start should be made in this direction as soon as possible so as to avoid the possibility of providing something that in the long term proves to be superfluous.

At this stage, one may add that if increased domiciliary services are able to help elderly people live in their own homes or alternatively in sheltered housing an invaluable contribution will have been made towards assisting the Welfare Committee to plan their capital development programme in a way leading

ultimately to a reduction in residential places which can then be used solely by those who really need this kind of care.

At present the persons most frequently involved in the early domiciliary care of the elderly comprise the doctor, district nurse and health visitor. The need for a routine visit by the health visitor to the elderly is gradually gaining recognition and in association with the Executive Council, registers are being compiled of the elderly who are on the lists of particular general practitioners. This is of considerable value for a variety of purposes but in this context enables someone with a complete knowledge of all the available medical and social services to assess needs and initiate the action required. Almost everyone is on the list of a general practitioner and the health visitor can pay particular attention to those at "risk" viz. those living alone, recently bereaved, etc. Ultimately, one can envisage this developing into a comprehensive preventive service as did the early pioneer work with children but because of different circumstances existing today as a partnership with the general practitioner and the local authority and voluntary services.

Although much is rightly made of the doctor/health visitor/nurse relationship others in their own fields contribute greatly to this work:

1. Home Help—to provide domestic help including the preparation of meals to promote adequate nutrition when alternative sources are unavailable.
2. Chiropodist—to assist in keeping the old people mobile.
3. Occupational Therapist—to assist with rehabilitation.
4. Social Workers in Mental Health—there are many old people who retire to Devon leaving behind friends and interests of a lifetime. Some find it difficult to take up new interests and make new friends and bereavement adds yet another problem. Mental ill health, particularly depression, is a common experience and women are more likely to be involved.
5. Voluntary Organisations especially as regards meals on wheels, clubs, etc.
6. The County Welfare Department—especially as regards certain community services, assessment of need in relation to accommodation, including short stay or permanent, admission to homes and holiday arrangements.

Mention must be made of the retirement clinics conducted jointly by the general practitioners and the local health authority staff. Much previously undetected physical and mental ill health is being diagnosed and the necessary treatment instituted. In some instances there are social conditions, the alleviation of which is contributing to improved health and well-being. The longer term beneficial effects of all this are likely to lead to reduced demands upon residential care and hospital beds. The full report of this work is given on page 76, but the following example has been picked out as it typifies the beneficial financial effects. Glaucoma is an eye disease that untreated leads to permanent damage and ultimately blindness. Four per cent of the elderly seen at the clinics have now been diagnosed as suffering from glaucoma and successful treatment has been instituted with a probable net saving to the Blind Welfare services in excess of the entire cost of the retirement clinics.

As there is a need for the greatest possible degree of co-operation the health centre again becomes the key which enables those most engaged in this work to communicate freely about the various problems and the many ways in which co-ordinated help can be offered.

The above work of the local authority is still only outlined, for this is a complex subject and involves many more statutory and voluntary agencies beyond the scope of this report.

Enough has probably been said to show that the work of those concerned with the care of the elderly has, in addition to its medical and social aspects, a no less important economic implication. If the bodies concerned can be encouraged to operate jointly along the preventive medico-social lines, a comprehensive service can be provided for the ever increasing numbers of elderly in ways which the elderly themselves would prefer, and at a much lower cost than might otherwise be necessary.

Health Centres

Already it has been shown repeatedly that the health centre is a key project in the organisation of the various specialist services.

Several other departments of the County Council also make use of these centres.

Closer working can only lead to higher quality work and more efficient use of too few staff—to the mutual advantage of the doctors, County Council personnel and the patients, who appear to be overwhelmingly in favour of the system. For the doctors there is another factor as generally the improved accommodation allows them to employ staff and this coupled with additional facilities and equipment results in considerable benefit to the population. Likewise the public knows that by visiting the health centre they will be put in touch with the person who is most likely to be able to offer help, rather than having to visit a number of buildings in order to find the appropriate agencies or agency.

Health centres provide the means for preventive work which will ultimately have favourable results both in financial terms and as regards improved health.

This is all achieved at less cost to the County Council than if a comparable clinic had been erected. This is because so much of the accommodation, furniture, equipment, etc., is used jointly with the doctors' full share being paid at the economic rate. In many ways Devon is fortunate in having so few post-war clinics as this has meant that the local health authority services have also been in urgent need of new premises.

Whilst the Government and the general practitioners are urging the erection of health centres any undue delay in their provision may produce an adverse financial situation on account of the doctors feeling obliged to make their own separate arrangements for improved accommodation which they need in order to raise the standard of service they wish to provide. We should then find ourselves unable to provide the public with many of the advantages already described and a partial provision would prove proportionately more costly to run in addition to being less satisfactory.

Summary

True economy is to spend money wisely—and this is true particularly in times of economic crises. It is also true that prevention and early diagnosis lead to a better service and to a less expensive one.

We cannot put a price upon a human life or a disease prevented or diagnosed and treated at an early stage. But we have seen that the humanitarian and financial aspects are both pointing the way for future services.

Clearly, there is a need for more and better hospitals and residential accommodation, but we should ensure that it is used only when domiciliary and

other services cannot do the job as well. We should remember that few people really prefer to enter any type of institution if there are other ways of meeting their needs.

In both physical and mental health, the national economy is best served by reducing incapacity and returning people to productive work as quickly as possible. This is what the Health Committee is trying to do.

I would like to acknowledge the help in the preparation of this report which has been given by Mr. M. Thompson the Deputy County Treasurer and Mr. N. Stevenson, Miss S. Williams the Deputy County Welfare Officer and Mr. E. Grimes the Information Officer.

PART VII

Child Health Services

The Health of the School Child

The Annual Report of the Principal

School Medical Officer, including

The Report of the Principal School Dental Officer

CHILD HEALTH SECTION

SCHOOL HEALTH SERVICE

HANDICAPPED CHILDREN

JUNIOR TRAINING CENTRES AND HOSTELS

DAY NURSERIES AND CHILD MINDERS

SPECIAL FAMILIES

LIAISON WITH OTHER DEPARTMENTS

The child health section was introduced in 1961 and covers all local authority health services available to children between the age of two years and school-leaving age. There is, of course, no hiatus at the extremes, liaison with the maternity and infant welfare and adult health sections being close and continuous. This administrative division is unusual in that it includes the community care of mentally handicapped children, a service more often included in the mental health sections of health departments. Here in Devon, by having a more comprehensive child health section, we ensure that these handicapped children receive continuity of care and are dealt with by the same professional and administrative staff between the ages of two and sixteen, thus emphasizing our belief that these children should not be cut off from the main stream of community child care.

In the field, the care of all children from birth to sixteen is the special responsibility of both assistant county medical officers and health visitors, and while help and supervision are still available through them after this age, this is supplemented in the case of E.S.N. and severely subnormal children and handicapped children by social workers from the adult health section who assist in effecting liaison with youth employment officers, disablement resettlement officers and others operative in the adult working world. Over the age of sixteen years, physically handicapped young people are the responsibility of the welfare department.

On the central staff there is a senior medical officer responsible under the county medical officer for the administration of the section, assisted by a senior assistant medical officer who does all work connected with Day Nurseries and Children Minders, the superintendent health visitor, a health visitor experienced in the care of special families and clerical staff of four dealing with detailed administration of the separate sub-sections. We are fortunate in having an excellent clerical staff who give unstinted hard work and loyalty to the section.

The work of the section increases steadily, but unfortunately the number of staff in the clerical section does not. This results in a heavy workload for all staff, with inadequate reserve for emergencies, illness or holidays.

SCHOOL HEALTH SERVICE

1967 was a difficult year for the school health service because of shortages of medical staff. We were fortunate to enlist the services of a number of part-time doctors who, often with no previous experience of preventive medicine, undertook the routine school health work. In spite of this, it was not possible to maintain a full service in all areas throughout the year.

More specialised work such as assessment of educationally and severely subnormal children in these areas had to be undertaken by medical staff from neighbouring parts of the county and from County Hall.

The likelihood of employing full-time career medical officers in local authority work in the future seems remote, and in the long term the school health service standard is likely to fall as a result of this. Even after recent salary awards there is no financial inducement for a young doctor to enter local authority work.

Apart from their visiting work and attendance at medical inspections, the health visitors and clinic nurses do much routine work in the schools. School children have an annual vision test and an annual hearing test. In some schools a termly hygiene examination is also considered necessary.

This work also gives the nursing staff a useful opportunity to talk to and appraise every child.

In few schools is it possible to have the necessary medical inspection room, and visits to the schools, especially the smaller ones, by the many and various members of the school health service must at times cause difficulties and disruption. The goodwill and co-operation of head teachers, which is invariably found, is much appreciated. Nevertheless, the dissatisfaction of all medical officers at the conditions under which they are expected to work, must be recorded. Even in new primary schools a purpose-built medical inspection room is not included, and inspections have to be done in a room vacated for the occasion by the school secretary or head teacher.

Administration

The numbers of children on the school registers are as follows:

Primary Schools	.. .. .	41,368
Secondary Schools, Grammar Schools, and Comprehensive Schools	.. .. .	26,975
Special Schools	.. .. .	453
Independent Schools	.. .. .	795
Total	.. .. .	69,591

Direct control of this service is vested in the school health sub-committee of the education committee, and we are particularly fortunate in this county in the friendly and effective liaison between education and health departments.

At the end of the year there were twenty-two school medical officers in the field, seventeen of whom are part-time and seven of these hold mixed appointments as assistant county medical officer and district medical officer of health. They arrange their own school programmes and are responsible for advising head teachers of impending school medical inspections. Needs vary widely in a county of such size and diverse nature as Devon and a delegate

function such as this has much to commend it. All school medical officers have a degree of independence which encourages interest and responsibility and allows the development of varied skills.

School Medical Inspections

The compulsory school medical examination of school entrants remains the keystone on which the school health service is built. It may be the first complete medical examination the child had had and its value is heightened by the opportunity afforded to the parents to discuss with the school medical officer any problems which they have concerning the child. Some medical officers use the selective system for examination of intermediate age groups, others continued with the examination of all pupils at this age. This is a decision for the individual preference of the medical officer concerned and is still a matter of some controversy. Those who use the selective system find it rewarding in that they are able to spend more time with children having a definite symptom; those who examine all children routinely feel that defects may be missed if selection for examination is made on the basis of a complete questionnaire, or the recommendation of the school nurse or teacher. A Medical Officer Reports "Many of the children starting school for the first time, are already quite well known to us from the child welfare clinics and this makes the first examination much easier, especially when dealing with children who may need special schooling or handicapped children. I find examination at 8 years and 11 years a useful procedure and as I can find time to do this I hope to continue with routine examinations at the present. This, I find is a good way to keep contact with the families, seeing all the children as they grow up and being readily available if help is needed."

All children have a final medical inspection before leaving school. The general trend of less physical defects and more emotional problems is especially noticeable at this medical inspection; with a need to spend more time with each child.

The frequency of visits to each school varies. Some medical officers are arranging with head teachers to divide up the year's work so that the medical officer visits the schools each term routinely and is thus able to establish a much closer liaison with both pupils and staff. It has not been possible for all medical officers to complete their school work within the year.

School Medical Records

In spite of the success of the pilot scheme at Tavistock in keeping school medical records in the clinic rather than the schools, it has not yet been possible to extend the scheme further. The extra cost of clerical staff at the clinics should be offset to a large extent by a lesser demand on school clerical staff but the years go by and in spite of repeated requests the old unsatisfactory arrangement remains. It is almost unbelievable that in a county such as this such a comparatively small improvement should be so difficult to put into effect.

A—Periodic Medical Inspections

The number of children classified unsatisfactory will depend very much on the medical officer doing the examination. Different standards are held by different medical officers, and therefore these figures do not give a reliable guide to the standard of health of the children examined.

Age Groups Inspected (By year of birth)	No. of Pupils inspected	Physical Condition of Pupils Inspected	
		Satisfactory	Unsatisfactory
		No.	No.
(1)	(2)	(3)	(4)
1963 and later	61	60	1
1962	4,083	4,078	5
1961	2,757	2,746	11
1960	702	700	2
1959	2,329	2,318	11
1958	1,913	1,909	4
1957	712	708	4
1956	1,184	1,180	4
1955	1,980	1,972	8
1954	833	831	2
1953	849	848	1
1952 and earlier	3,097	3,086	11
Totals	20,500	20,436	64

B—Other Inspections

Number of Special Inspections	.. .. .	427
Number of Re-inspections..	.. .. .	3,607
Total	.. .. .	4,034

C—Pupils found to require Treatment at Periodic Medical Inspections
(excluding Dental Diseases and Infestation with Vermin)

Notes: Pupils found at Periodic Inspections to require treatment for a defect are not excluded from Table C by reason of the fact that they were already under treatment for that defect. Table C relates to individual pupils and not to defects. Consequently, the total in column (4) will not necessarily be the sum of colums (2) and (3).

Age Groups Inspected (By year of birth)	For defective vision (excluding squint)	For any of the other conditions recorded in Part II	Total individual pupils
(1)	(2)	(3)	(4)
1963 and later	—	3	3
1962	58	201	218
1961	41	204	200
1960	9	61	55
1959	58	142	174
1958	56	192	182
1957	21	103	77
1956	23	131	112
1955	84	231	248
1954	31	115	106
1953	52	89	107
1952 and earlier	137	347	389
Totals	570	1,189	1,871

Return of Defects by Medical Inspection in the Year ended 31st Dec., 1967

Note: All defects noted at medical inspection as requiring treatment are included in this return, whether or not this treatment was begun before the date of the inspection.

Defect Code No.	Defect or Disease	PERIODIC INSPECTIONS		SPECIAL INSPECTIONS	
		No. of defects		No. of defects	
		Requiring treatment	Requiring to be kept under observation but not requiring treatment	Requiring treatment	Requiring to be kept under observation but not requiring treatment
	(1)	(2)	(3)	(4)	(5)
4	Skin	414	412	6	1
5	Eyes— <i>a.</i> Vision	593	538	8	—
	<i>b.</i> Squint	143	202	4	—
	<i>c.</i> Other	59	111	2	—
6	Ears— <i>a.</i> Hearing	96	647	5	3
	<i>b.</i> Otitis Media	37	482	7	14
	<i>c.</i> Other	17	52	—	2
7	Nose or Throat	146	813	6	3
8	Speech	103	438	6	3
9	Lymphatic Glands	11	355	1	1
10	Heart	30	90	—	—
11	Lungs	98	476	23	6
12	Developmental—				
	<i>a.</i> Hernia	22	41	1	1
	<i>b.</i> Other	45	298	5	1
13	Orthopaedic—				
	<i>a.</i> Posture	29	188	7	—
	<i>b.</i> Feet	123	399	6	6
	<i>c.</i> Other	100	370	9	5
14	Nervous system—				
	<i>a.</i> Epilepsy	34	77	3	2
	<i>b.</i> Other	33	135	7	1
15	Psychological—				
	<i>a.</i> Development	127	405	9	9
	<i>b.</i> Stability	106	666	5	19
16	Abdomen	22	120	3	4
17	Other	28	160	—	2

Infestation with Vermin (Head-lice)

Neither cleansing notices nor cleansing orders were issued during the year, the policy being that a friendly approach to the parents is more effective in the long run.

The schools in most areas are completely free from infestation, in others it is a constantly recurring problem. In 1967 there was a slight increase in infestation in some areas. A determined and energetic school nurse can do much to reduce the incidence, and it is to be hoped that with the easy, pleasant, modern treatment, infestation will soon become a thing of the past.

Infestation with Vermin

(i)	Total number of examinations in the schools by the school nurses or other authorized persons	91,094
(ii)	Total number of individual pupils found to be infested . .	221
(iii)	Number of individual pupils in respect of whom cleansing notices were issued (Section 54 (2), Education Act, 1944)	—
(iv)	Number of individual pupils in respect of whom cleansing orders were issued (Section 54 (3), Education Act, 1944) . .	—

Chiropody

Several medical officers report an increased incidence of verrucas in their areas. The County Chiropody Service has been able to help both with treatment and with foot inspections in schools.

School Transport

At present a medical officer can recommend school transport as either essential on medical grounds, or as desirable on medical grounds. The latter recommendation is not usually supported by the Chief Education Officer.

Cases do arise where transport is essential on social grounds and such cases are given sympathetic consideration by the Chief Education Officer.

Nocturnal Enuresis

The electric alarm apparatus was out on loan during the year and continues to be of valuable service. If it does not actually produce 100 per cent cures in all cases it does demonstrate to the child concerned that he is capable of having dry nights. This realisation makes the child and the parents much happier and in one or two cases an improvement in the child's school work has also resulted. The family doctor is consulted in all cases before treatment is commenced. This group of children needs our help but unfortunately parents are often reluctant to bring them forward for treatment. There is no doubt, however, that the success obtained with the alarm has brought many mothers to the Clinic to enquire about it and ask for help.

We are using the alarm for five-and six-year-old children now, as well as for older children. It is just as effective with the younger children and usually the time required to establish control is much shorter than with older children.

Relationship with G.P.s

On the whole this is excellent, and medical officers are encouraged when they first take up their duties to visit all G.P.s in their area, making themselves known to facilitate later contacts. Any child found at a school medical inspection to require treatment is referred to the G.P. by letter or 'phone, and where specialist advice is necessary a consultation form is completed and sent to central office: notice of this is sent to the G.P. with a proviso "If you have any objection to this course of action, please inform me within seven days. If I do not hear from you I shall assume that you have no objection, but if you have any further details of the child's medical history which you think may be of help perhaps you will be kind enough to send these to me or direct to the consultant. A copy of the consultant's report will be forwarded to you," which gives an opportunity to object but saves the G.P. any trouble in replying if he is agreeable.

ANCILLARY SERVICES

There are many services which, whilst disciplines in their own right, also provide ancillary help essential to the proper functioning of the school health service.

Child Guidance

There are three clinics in the county situated at Barnstaple, Torquay and Exeter, the latter being a joint clinic with Exeter City. The teams are headed by psychiatrists who give varying amounts of time on a sessional basis. Children from the south-west of the county are referred to the Nuffield Clinic at Plymouth where Dr. Weeks and Dr. Mathews see them for us.

We were very pleased to welcome Dr. P. M. Jackson, who was appointed medical director of the Torquay Child Guidance Clinic with effect from 1st November, 1967. His report is appended.

In addition to their ordinary work, the psychiatrists give much valuable time to meetings with health visitors and school medical officers to discuss cases of mutual concern and to advise on child guidance in general. This in-service training is of incalculable benefit and we are most appreciative of such constructive help.

A medical officer writes:

"I am grateful to be able to attend Dr. Wardle's Child Guidance Clinic at Barnstaple. I do this once a month and find this most helpful in finding out which type of case can be most usefully referred to him. I also meet the educational psychologist, and remedial teacher at the clinic which is a most useful contact."

Exeter Child Guidance Clinics

Dr. Gaussen reports:

This report, for the year 1967, is my last as Medical Director of the Exeter City and of the East Devon Child Guidance Clinics. The City Clinic opened in October 1947 under my medical direction, and I started working for Devon County Council soon afterwards. In 1963 the two clinics were housed in our present premises and have worked together very closely, being financed by the two Authorities and the Regional Hospital Board. Work and staff have increased and the link with the hospitals is bound to get closer. The term "Child Guidance" is still a useful one but the emphasis has changed, over the years, and now lies on family and parental guidance. In the twenty years, it has been recognised that the psychiatric problems of the child differ from those of the adult, and that the main hope of community mental health lies in prevention and education during the formative years.

Although this is a report for the past year, I hope I may be allowed a glance at the future in the light of my experience. Those who have followed the development of social services for children and their families will realise that there has been a great proliferation of these services and that an immense specialization has been going on. Unfortunately, children only too often have multiple handicaps, and there are deep gulfs between the various agencies. There is a very real danger that the child as a whole may be lost. The child is not a diminutive adult, and his handicaps are threats to his becoming fully grown. The mental and physical aspects of life are often considered separately, for convenience, but this is very seldom justified in childhood. A broken leg at a crucial time may retard education and alter the course of a life.

Child Guidance has stood for team work, for the integration of the social, the educational and the medical aspects of work with children in difficulties. It has stood for the pooling of information about a given child in its family setting, in his school, with his particular medical problem. The psychiatric social worker, the educational psychologist and the psychiatrist all contribute, in varying proportions, and the decision is that of the team. Each member is a specialist in his or her own field, each is in touch with others of his discipline. Child Guidance has come, therefore, to stand for an approach to the whole child in its environment — an environment which may itself need alteration and improvement. The members of the team learn from each other.

Child Guidance stands, also, for a key position, a vital link in the social services. It serves the deprived, the delinquent, the maladjusted child. With these other agencies are also concerned, and few children seriously at risk escape from involvement with two or three. It is part of the Local Authority service for children at its school and, therefore, part of the school health and welfare services.

Child Guidance stands for case work with the individual child and his family. It is not only for those who have fallen by the wayside but also for those who need a far-seeing approach to some personal problem. Bereavement or a broken home may mean a crisis with grave social, educational and medical problems which only a personal relationship with workers of skill and experience can resolve. Or a gifted child may be in danger of breakdown just because of the number of choices before him.

I would like to conclude this rather personal report with thanks to the Committee who has supported the Clinics and to all the members of their staff who have co-operated so closely with me. The place of Child Guidance in the community is a unique one — I hope and trust that the value of the team approach to children's problems will always be maintained.

Torquay Child Guidance Clinic

Dr. Jackson reports:

“An analysis of cases under treatment during 1967 has been carried out; the figures recorded are shown at the end of this report.

I am pleased to say that we have managed to keep the waiting list down to such proportions that I can see them all within two or three weeks of being asked, so that I feel I am able to give an opinion as to the suitable treatment etc. and whether we can be of any help to the particular case. How long we will be able to do this, remains very much to be seen. The analysis is attached to this letter.

My only comment about this superficial analysis is that we do seem to be getting a lot of behaviour disorders and that many of these are related to so called “problem families.” These of course are particularly resistant to psychotherapy or any form of psychiatric treatment. I am rather concerned that we are not getting really the right number of patients suffering from neuroses or psychoses or developmental disorders. It does tend to suggest that people have to misbehave themselves before they are referred, and that many children who are perhaps withdrawn and quiet have been missed. However, this remains to be seen.

As far as the age on referral is concerned, we do seem to be getting several adolescent problems, but we do not seem to be getting the really disturbed

young children until they are about 8 or 9 years of age. This I feel is much too late, and would prefer them when they are about 6 or 7. Therefore, there seems to be some delay in referring this age group, i.e. a latency period.

As far as the agencies referring the cases are concerned, I have had a word with the Children's Department and they tell me that Miss Edwardson appears to do most of their work for them, and as she appears to be able to do it very well, it is understandable that we are getting so few cases from them. However, I think some explanation is called for so far as the Probation Department is concerned.

Another point which is of interest to me, is the number of cases referred by the parents themselves. I also feel that since I have been going to Torbay Hospital the number of cases referred from the paediatric department is increasing rapidly. Some of these cases of course have been seen by Dr. Christopher Wardle, in Exeter, in the past.

Lastly it is interesting to note that there are as many cases outside Torbay as there are in the area.

ANALYSIS FOR 1967

(Treated cases)

(1) Place of residence:

Torbay	..	..	..	..	..	40
Outside Torbay	..	..	..	..	..	39

(2) Age on referral:

*Age	No.	Age	No.
4	4 (3)	9	6 (14)
5	6 (5)	10	15 (—)
6	3 (3)	11	2 (7)
7	12 (—)	12	8 (—)
8	3 (10)	13	4 (14)
		14	10 (4)
(2)	(1)	15	6 (—)
(3)	(4)	(16)	(2)
		(17)	(4)

(3) Diagnosis:

Neurosis	..	..	..	..	14
Educational Problems	..	..	..	..	7
School phobia	..	..	..	..	5
Behaviour disorders	..	..	..	..	48
Psychosis	..	..	..	..	1
Developmental disorders (organic)	..	..	..	..	4

(4) Agency referring cases:

Family doctor	..	..	..	..	23
School(headmaster)	..	..	..	..	12
Educational Psychologist	..	..	..	..	9
Local Authority (S.M.O. etc)	..	..	..	..	17
Probation Department	..	..	..	..	3
Children's Department	..	..	..	..	2
Parents	..	..	..	..	9
Paediatric Department	..	..	..	..	4

79

* The figures in brackets are the ages of the non-treated, closed, cases etc.

REFERRALS TO CHILD GUIDANCE—1967

Total no. of referrals in 1967—147

Medical:	G.P.'s	40	
	S.M.O.'s	23	
	Health visitors	1	
	Paediatricians	6	
	P.S.M.O. (Devon)	3	
	P.S.M.O. (other)	1	
	Other C.G.C.s	6	
	Other P.S.W.s	1	
		—	81
Educational:	Educational Psychologist	22	
	C.E.O.	1	
	D.E.O.	2	
	Head Teachers	8	
		—	33
Social Agencies:	Court	8	
	Probation Officers	6	
	Children's Department	2	
		—	15
Parents:	.. .. .	16	16
Others:	Capt. Parry Brixham Boys' Home	2	2
		
			147
<hr/>			
Referrals in 1967	147		
1966	178		
1965	179		
1964	169		

North Devon Child Guidance Clinic

Dr. Wardle reports:

"The work of the North Devon Child Guidance Clinic in 1967 has continued, slightly hampered by the absence of a full time Educational Psychologist though we have been most grateful for the help given us by Mr. Love, the, Senior County Educational Psychologist. This has inevitably led to a reduction of the work possible. The Clinic premises have been very much improved by setting up a playroom and by general redecoration.

In June 1967 the Dryden Childrens Unit was opened with 17 beds for inpatients and 10 day places. This is a fully staffed Unit for the investigation and treatment of children aged 7—14, sited in a modernised wing of the Exe Vale Hospital, Wonford; it is quite separate from the rest of the hospital. The Unit incorporates a school run by a Head Teacher, trained to teach mal-adjusted children, and an assistant Teacher. The staff includes a Psychologist (p.t.) Psychiatric Social Worker (p.t.) Occupational Therapist and Medical Registrar, and is under the direction of the Consultant in Child Psychiatry, Dr. C. J. Wardle.

It is intended that this Unit will enable us to investigate emotionally disturbed and maladjusted children, and will enable us to provide treatment for short term and long term for such children, without having to send them out of Devon. The Unit will cater for all forms of emotional and behavioural disorder, however severe. It will also cater for less severe difficulties, where the child needs a period away from home or the highly specialised type of treatment which we can offer. The type of problems we are dealing with at present include:—

- School phobia.
- Intractable bedwetting and encopresis.
- Depression.

- (d) Children who have repeatedly absconded from home and school.
- (e) Children whose emotional upset is leading them to be grossly retarded educationally.
- (f) Children with severe anxiety symptoms.
- (g) Psychotic children.
- (h) Children whose relationships at home have gone awry.
- (i) Epilepsy and other forms of brain injury and disease.

The therapeutic environment which we have been able to set up has made it possible to nurse this great variety of children in what we regard, as a very happy and enthusiastic community, in which all the children seem to participate readily.

An Adolescent Clinic has now been started at the Royal Devon and Exeter Hospital on one Thursday evening each month.

We continue to provide six beds for adolescents between the age of 15—17 at the Exe Vale Hospital, Wonford.

There continues to be a need for small classes for maladjusted children throughout the area. Were these available I feel quite confident that we could cut down the number of children that have to be placed in special boarding schools. I would suggest that the first of these classes would be set up in the proximity of the Hostels for maladjusted children at Crichel and Willand, since admission of maladjusted children to these Hostels must inevitably lead to a burden on the schools which serve them. The day unit at the Hospital can cater for a limited number of children, who live close enough to Exeter, and already we have had two county children in the day hospital, with considerable benefit. Barnstaple would seem to be the next place of choice for the establishment of a tutorial class for maladjusted children, and this might be considered in association with the new E.S.N. school there.

Number of pupils treated at child guidance clinics under arrange- ments made by the authority	947
Total Number being treated 1st January 1967	514
Residential	33
Number on waiting list 1st January, 1967	60
Number referred during 1967	390
Number discharged during 1967	437
Number being treated 31st December, 1967	481
Residential	29
Number on waiting list 31st December, 1967	50

Educational Psychologists

There are six educational psychologists including the senior, Mr. P. C. Love who work closely with the school medical officers. Where it is necessary to complete form 2 H.P. the educational psychologist completes the first part and the medical officer the remainder, the examination including an audiogram. The final recommendation is made by the senior school medical officer, after consultation with the senior psychologist, an arrangement which is working smoothly.

HEARING ASSESSMENT CLINICS

Four of the school medical officers have received special training in the assessment of deaf children and four hearing assessment clinics have been established to date for North Devon, East Devon, the Torbay area, and West Devon. Some children from the south and west are referred to Plymouth hearing assessment clinic.

All children receive regular hearing tests in school and those in whom there is reason to doubt aural acuity including pre-school children, are referred to the hearing clinic run by these school medical officers. If found to be deaf they are passed to the hearing assessment clinic at which an E.N.T. consultant attends as well as the medical officer and other interested workers, e.g. peripatetic teacher for the partially hearing, audiometrician, speech therapist, health visitor. A decision is made there as to the best medical treatment and education for the child.

A medical officer reports:

"Among our pre-school patients, most are referred because of late speech development. It is, of course, essential to be satisfied that these children are not being impeded in language development by inability to hear speech but the number who prove to have hearing loss is small in relation to the total number of children with late speech. The importance of speech and language, both as matrix and as end-product, in the general development of intelligence and the social and educational attitudes of young children is only just beginning to be recognised. It has still to be investigated, understood and interpreted to those of us who deal with young children daily. It is easy enough to appreciate the handicap of a child who cannot walk; it is fairly easy to imagine oneself into the silent world of the deaf, but the world of the child who hears, but attaches no meaning to speech and who sets out to build up thought without language, is unexplored and, as far as I can see, is closed to those of us who think in words and sentences. These children without auditory language are, probably, just about as rare as the profoundly deaf child, but there are clearly many children whose speech comes late and whose language is permanently impoverished, limiting the development of ideas, imagination and connected thought. In treating these children, speech therapists have to go back to the infant stage in which the auditory and visual and tactual characteristics of a given object are repeatedly investigated at one and the same time before any effort towards speech is made, just as the physiotherapist has to work at head, neck and trunk control in the recumbent backward child before attempting to get the child to sit and then stand.

The situation seems to call for an expansion of interest in the language defective child; an expansion of the same order and with even more potential benefit in educational treatment than the explosion of interest two or three decades ago in the deaf and partially-hearing child."

AUDIOMETRY

Work in the field of hearing and speech increases every year. This service includes three essential parts:

1. Screening in appropriate age groups to demonstrate normal hearing and language development.
2. Investigating children who fail these screening tests.
3. Treating the children shown by investigation to be defective in hearing or speech.

Hearing test for infants are carried out routinely according to the methods recommended by Manchester University by health visitors before the first birthday. There is close supervision and testing of all babies known to be at risk. Health visitors also carry out vocabulary tests for hearing when a child enters school and subsequently each year. Any child suspected of a degree of deafness is referred to the hearing clinic and an audiogram is requested by the medical officer. The audiometricians have also carried out a number of sweep tests in schools throughout the area. They attend at hearing assessment clinics and do a great deal of work in the testing and care of hearing aids.

Audiometricians' Report

Total number of audiograms	3,519
Number of children "Sweep" Tested	435
Number of hearing aids issued (all areas)	27
Hearing aids tested	347
Sent for repair	100

The county paid for 8 commercial A.V.C. Hearing Aids for special cases during the year. These are supplied on the recommendation of the E.N.T. consultant, usually for cases of high frequency deafness.

SPEECH THERAPY

In 1967 the South Western area continued to be under-established; throughout the year there was no clinic in the Holsworthy area, but the Tavistock Clinic was re-opened in September when seven schools were visited in order to see the seventy children referred and awaiting treatment.

In November Mrs. Brookes was appointed to take over the Kingsbridge Clinic, and during the year nine schools were visited in this area. In the Newton Abbot are three schools were visited and a regular clinic at Milber was commenced as twenty-five children at this primary school were in need of treatment.

There was a change of therapist at Combe Pafford School in September, and the Pitt House Junior School at Chudleigh was temporarily discontinued. Several home visits were made, also to Villa Langard.

A short course of three talks followed by discussion was held at Downham for parents of children at this school. Also a discussion session with all the teachers at Milber County Primary School. An afternoon talk was given to the Young Wives Group at Modbury. The Head Master of Combe Pafford invited the speech therapist to speak at one of his parent and staff evening meetings on the same occasion as the School Dental Officer. These talks were followed by a fruitful discussion.

The Torbay area clinics continued to have large attendances and waiting lists, and in November all adult patients receiving speech therapy in this area were transferred from the County Therapist to a newly appointed therapist to the Department of Speech at Greenbank Hospital, Plymouth.

It was with regret that we lost Mrs. Tozer from Downham in the autumn when she had to move with her family to Scotland, but we were pleased to welcome Mrs. Mosdell who is at present working at Maristow House.

The number of children requiring speech therapy in Moretonhampstead became less, this clinic was therefore discontinued in favour of treatment for children in the Tedburn area.

Speech Therapy Clinics — Annual Returns of Work for 1967

No. of Area Officers	No. of clinics operating	Cases discharged during year	Under treatment at end of year	Under observa- tion	Awaiting treatment	Totals
E. Devon (3)	12	89	60	28	15	192
W. Devon (1)	8	68	39	61	74	242
N. Devon (2)	11	65	97	42	75	279
S. Devon (2)	9	59	129	65	33	286
Totals (8)	40	281	325	196	197	999

Speech Therapy—Diagnostic Categories of Cases—treatment completed

Delayed Speech	.. .. .	68
Cleft Palate	.. .. .	8
Cerebral Palsy	.. .. .	1
Articulation Defects	.. .. .	121
Dysphonia	.. .. .	5
Hearing loss	.. .. .	5
Stammer	.. .. .	28
Others	.. .. .	45
		281

SCHOOL OPHTHALMIC SERVICE

Every child received an annual vision test in school and those whose acuity was less than 6/9 in one or both eyes were referred to one of our four part-time ophthalmic specialists.

The geography of the county and availability of suitable clinic space have, between them, dictated the development of the school ophthalmic service as one primarily operated in schools rather than clinics.

Few schools have suitable facilities for this work, and with the development of Health Centres these will be used, subject always to the convenience of schools and parents and to facility of attendance.

A useful meeting was held in February 1967 between the ophthalmic specialists and the school health service at which points of difficulty were discussed.

It was agreed that the form of consent for attendance at the clinic should be modified to include written consent to the instillation of drops, as in some cases children attended without their parents.

A local arrangement whereby children's spectacles must be sent to the Exeter Eye Infirmary for consent for repair was criticised. As in neighbouring areas, it was suggested that a local optician should be able to repair the spectacles at once, but this matter is still being considered by the local executive council.

EYE DISEASES, DEFECTIVE VISION AND SQUINT

	Number of cases dealt with
External and other, excluding errors of refraction and squint	2,680
Errors of refraction (including squint)	12,125
Total	14,805
Number of pupils for whom spectacles were prescribed	4,023
Total number of sessions held at schools	254
Total number of sessions held at clinics	590
Total number of school children seen	12,074
Total number of pre-school children seen	3,765

TEN YEAR RECORD OF ABOVE TABLE

	<i>Number of cases dealt with</i>	<i>Number prescribed glasses</i>
1958	11,261	2,269
1959	9,225	2,861
1960	9,890	1,771
1961	11,071	2,072
1962	11,063	1,179
1963	10,648	3,101
1964	11,575	3,434
1965	11,321	3,858
1966	11,577	4,079
1967	14,865	4,023

HANDICAPPED CHILDREN

The introduction of developmental clinics (reported elsewhere) should ensure the early detection of handicaps, and is a most desirable innovation.

In many cases, before ascertainment can be made, many opinions must be sought from workers specialising in one aspect of the problem of handicapped pupils, e.g. G.P. paediatrician, speech therapist, peripatetic teacher of partially hearing, educational psychologist, etc. The medical officer having received these opinions must co-ordinate them and assess the child as a whole, before making his recommendations to the parent and the education authority. Even in cases where formal ascertainment is no longer required (e.g. prior to admission to day-schools for the E.S.N.) it is still the duty of the school medical officer to assess the child comprehensively. Without this careful evaluation mistakes in diagnosis and placement will occur.

A medical officer reports:

“Consultation with Youth Employment Officers about handicapped school leavers long before they were due to leave school, has often enabled these children to be fitted into suitable jobs or sent to college for training. Similarly at the Leaver Medical Examination at school, advice about medical standards and requirements can often help a young person choosing an unsuitable occupation.”

Handicapped children may not leave special schools until they are 16 years old, but a scheme for continued care up to 18 years is being developed. The education authority's residential special schools have for some time been implementing schemes for ensuring appropriate placement and follow-up, teachers being especially allocated for this work. This type of work is also carried out by the social workers in mental health in appropriate cases.

During 1966 the school health sub-committee have agreed to pay for the attendance and transport of children to privately-run day nurseries, where the child is handicapped and in need of the stimulus of mixing with normal children. This arrangement has been extremely rewarding to the children concerned, especially children handicapped by a degree of deafness or maladjustment.

In a country area such as Devon, transport difficulties have in some cases prevented attendance where this would have undoubtedly benefited a child. It is unfortunate that Devon does not have and is unable to provide day nurseries in the main centres of population, not only for handicapped children, but also for the normal child who benefits enormously from mixing with his peers before attending school formally at the age of five.

Deaf School Leavers

The welfare officer of the deaf is invited to attend meetings of all workers concerned in the care of deaf children during the last year of the pupil's attendance at school, so that she is aware of any special problem and can pave the way for good care of the handicapped school leaver.

This arrangement has worked well.

Development Clinic at Barnstaple

Dr. Hall, acting medical officer reports:

"The Development and Assessment Clinic has continued in Barnstaple throughout the year. Despite many changes of the Medical Officer conducting the Clinic, attendance has been excellent and appointments kept regularly due to the very hard working and ever patient secretarial staff.

All the children seen have been referred by the General Practitioners presenting with problems in development or abnormal birth histories.

Total number of children attending from 1.4.67—31.3.68 — 45.

Girls — 16

Boys — 29

Total number of visits:—

	<i>Girls</i>	<i>Boys</i>
First visit	11	19
Second visit	7	9
Third visit	3	2
Fourth visit	0	5
Fifth visit	1	0
Sixth visit	1	0
	—	—
	23	35
	—	—

Reasons for Referral:—

GIRLS

At Risk	.. .. .	4
Slowness in speaking	.. ..	5
Spasticity	.. .. .	2
Physical	.. .. .	4
Speech defect	.. .. .	1
Slow Motor development	.. ..	1

BOYS

At Risk	.. .. .	4
Suspected poor hearing	.. ..	4
Slow motor development	.. ..	6
Slowness in speaking	.. ..	6
Poor general progress	.. ..	6
Mentally handicapped	.. ..	2

Handicapped Register

A register of handicapped children is kept in the central office and is compiled from reports sent in by medical officers, health visitors and others. A card is made out and sent to the medical officer of the area in which the child lives, a duplicate is retained so that before the child is due to start school notice may be sent to the medical officer concerned, to enquire whether special educational provision will be necessary if not already in hand, the whole purpose of a register being to ensure appropriate and continuing care for each child.

The numbers of handicapped children registered in the department at 31st December, 1967, were 1,139 children of school age and 254 aged two to five years. They fall into the following categories:

	5-to-16	2-to-5
Blind	11	2
Partially Sighted	21	14
Deaf	18	2
Partially Hearing	66	12
Epileptic	38	23
Delicate	155	51
Physically Handicapped	92	60
Educationally Subnormal	397	—
Maladjusted	63	—
Mentally Handicapped (unsuitable for education at school)		
Subnormal	212	54
Severely Subnormal	66	—

Partially Hearing Children

The great majority of hearing aid wearers manage very well in ordinary school with help from the peripatetic teachers of the partially hearing.

There are units for partially hearing children attached to a primary and a secondary school in Torquay, and to a primary school in Barnstaple.

Delicate and Physically Handicapped Children

Many children with physical handicaps cope in the ordinary schools or training centres available to others of comparable intelligence. Some children are remarkable in the way they overcome severe handicaps.

Dame Hannah Rogers' School at Ivybridge caters for physically handicapped children of average or E.S.N. intelligence; this is an independent boarding and day school which many Devon children attend.

Steps Cross School at Torquay, a day school of 90 places, has its full complement of physically handicapped pupils, and since an orderly has been appointed it has been possible to take chair cases, and other children needing more personal attention than previously. Several muscular dystrophy cases and partially incontinent children have now been admitted whereas previously only home tuition was available to them. Children with asthma or bronchiectasis constitute the majority of the pupils, and regular daily physiotherapy has improved or maintain their health so that regular¹ school attendance has been possible.

The teachers, the meals staff, the physiotherapist, the remedial occupational therapist, the taxi drivers and the pupils have such a close community spirit, inside and outside the school, that the well-being and educational progress of the child is their main concern. The full ordinary school curriculum is taught and a high proportion of children are selected for grammar school places.

Educationally Subnormal Children

There are four schools in the county for these children:

Maristow, near Plymouth (residential)	89 pupils (Girls)
Bradfield School, Willand (residential)	75 pupils (Boys)
Withycombe House School, Exmouth (residential)	45 pupils (Girls)
Combe Pafford School, Torquay (day)	125 pupils (Boys & Girls)

Devon County children also attend Longcause School, Plympton (day) and Southbrook School, Exeter (day) on an agency basis.

A school for E.S.N. children is being built in Barnstaple and will be opened in 1968.

There are also five full-time special classes in ordinary schools, and many part-time classes held by the peripatetic remedial teachers.

A medical officer reports:

“Southbrook Day School for educationally subnormal children opened during the year providing places for eight children from my area. They seem to have settled very happily there and the parents I have met are more than satisfied with the benefits the new school is offering their children. I understand that the provision of a Nursery and Assessment Class is envisaged at the school; this would be of inestimable value. At present the special training of our mentally and educationally subnormal children starts much too late. In the home and in the ordinary school the effort of good parents and teachers is bent upon teaching these children to behave in a way that is accepted as normal for their chronological age. Parents are rarely aware that much of the abnormal behaviour of the mentally handicapped child is appropriate to his mental age and is adapted

to his learning requirements at that mental age. Although teachers are aware of this the results are often too disruptive to be tolerated in the ordinary school. Mentally handicapped children need a special environment for at least part of the day from a very early age; the most important part of that special environment is a specially trained staff. It is most helpful to parents, at all stages in their children's education to have close contact with these specially trained teachers so that their expert understanding of their pupils can be passed on to the home. Parent-education and guidance, which is fundamental in the work of peripatetic teachers of partially hearing children, and in the work of physiotherapists dealing with physically handicapped children, is being extended to the parents of mentally handicapped children with great benefit to the entire family. There is real hope for the prevention of handicap, or at least its amelioration, if regular developmental assessments in the infant stage can identify the babies in need of special care and if trained people are available to work with the parents in giving that special care from the very first months of life."

Epileptic Children

Epileptic children are in the main contained within normal schools. A few are at special schools for epileptic children, but, as medical control of this disability has advanced, it becomes increasingly possible to integrate the epileptic child into the normal school community.

Maladjusted Children

Maladjusted children can be received into Crichel hostel at Totnes or The Gables at Willand. Those who are unsuitable for either, insofar as they are too disturbed to go out daily from the hostels to normal schools, are placed in residential special schools.

Special Schools

During 1966 Handicapped children from Devon have been placed in the following special schools:

PHYSICALLY HANDICAPPED

*Steps Cross Special Day School, Torquay

EDUCATIONALLY SUBNORMAL

*Maristow House School, Roborough

*Withycombe House School, Exmouth

*Bradfield School, Willand

BLIND AND PARTIALLY SIGHTED

Royal School of Industry for the Blind, Bristol

Dorton House, Sevenoaks, Kent

Condover Hall, Shrewsbury, Salop.

Sunshine House School, Northwood, Middlesex

West of England School for the Partially Sighted, Exeter, Devon

DEAF AND PARTIALLY DEAF

Royal West of England Residential School for the Deaf, Exeter, Devon

Hartley House School for the Deaf, Plymouth, Devon

Mary Hare Grammar School for the Deaf, Newbury, Bucks.

EPILEPTICS

Lingfield Hospital School, Surrey

DELICATE AND PHYSICALLY HANDICAPPED

Heathercombe Brake School, Manaton, Devon

Heathlands Rise School, Teignmouth, Devon

Victoria Home and School, Poole, Dorset

St. John's Open Air School, Woodford, Essex

Coney Hill Home School, Kent

Halliwick School, Bush Hill Road, Winchmore Hill, London

SPASTICS

Trengweath School and Centre for Spastics, Plymouth

Dame Hannah Rogers Schools for Spastics, Ivybridge, Devon

Chailey Heritage Craft School & Hospital, Sussex

* Devon County L.E.A. School.

PAIGNTON URBAN DISTRICT

OUTBREAK OF SONNE DYSENTERY—1967

"From the middle of January until the middle of March 1967 a total of 125 notifications of *sonné* dysentery was reported at Paignton. Routine investigations revealed many more cases than this mostly in other members of affected families and the grand total of cases discovered approached 180.

The outbreak began at Oldway Primary School with one or two cases, then it rapidly spread and within a very few weeks a large proportion of the children and some staff at the school had been affected. No direct link between this outbreak and one which occurred at the Roman Catholic School in November 1966 could be established. It should be noted that at about this time there were outbreaks of dysentery all over England and Wales especially in the densely populated areas and several of these outbreaks were on a far greater scale than took place at Paignton.

The maximum sickness rate at any one time at Oldway School was about 12%. Reports were received of children having suffered from diarrhoea but whose parents had not consulted a doctor and had allowed the children to return to school upon cessation of the diarrhoea. Thus a pool of symptomless carriers of infection was built up and such children almost certainly passed on the infection to their classmates. Only a minority of parents erred in this way but the fact they sent their untreated children back to school caused a great deal of damage and facilitated the spread of infection in the school.

As soon as it was realised that the outbreak at Oldway Primary School was spreading rapidly stringent hygienic precautions were instituted. The toilet accommodation was disinfected several times a day and this was especially necessary as the ratio of the number of toilets to the number of children using them was below standard due to rapid growth of the school population during recent years. The school canteen staff as well as all the staff at the school meals cooking centre at Tweenaway were tested and found to be free of infection. Water and milk samples were bacteriologically tested and found negative. Parents of known cases of diarrhoea were asked to not send their children to school without first consulting the family doctor and finally plastic bowls were provided in each classroom and children and teachers were made to dip their hands in a dilute solution of Benzalkonium Chloride (Roccal) which is known to kill *shigella sonnei* on the fingers in less than half a minute.

By employing these methods it was possible to keep the school open in spite of great pressure made by and on behalf of some parents to close the school.

During the first month of the outbreak the technical staff of the Public Health Department were able to follow up each case notified and arrange testing of all the other members of the family, most of whom subsequently developed the illness, although a few symptomless carriers were discovered. All "positive" cases were referred to the family doctor for treatment and after a course of treatment the patients were re-tested to find if they were clear of infection.

The laboratory at the Torbay Hospital carried out sensitivity tests upon the *shigella sonnei* organism and these showed that the Tetracyclines and particularly Neomycin were the drugs of choice in treating this dysentery. However it soon became apparent that a single course of treatment with Neomycin was often ineffective and that the organism was resistant to ordinary doses of the drug. After consultation with the General Practitioners concerned the dose of Neomycin was increased considerably up to a maximum of 4.0 grammes per day for adults, with proportionately less for young children. This routine worked well and by the end of February patients who had been symptomless excretors of *shigella sonnei* started becoming negative.

Because of the growth of numbers of cases in February it no longer became possible to follow up whole families and investigations were limited to testing children only, adults who worked in hospitals or the foot trade, and any persons who were contacts of infection and who were expecting for one reason or another to be admitted into hospital.

About the same time it was decided to stop demanding three consecutive negative clearance stool tests from treated patients as the numbers involved were too great for the public health department to handle. Instead, after consultation with the Director of the Public Health Laboratory at Exeter, and with the County Medical Officer it was decided to take only one clearance test a minimum of 72 hours after the family had completed treatment. The results of this routine were remarkably good and extremely few cases relapsed.

Although brothers and sisters of patients at Oldway School very often attended other schools in the area and in several instances caught the infection a rigid routine of school exclusion of these contact cases coupled with strict hygiene precautions in those schools prevented the outbreak spreading.

The peak of the outbreak was realised at about the middle of February 1967 after which the numbers of new cases steadily diminished. The outbreak had virtually ceased by the beginning of April.

I think that two factors contributed to the rapid spread of infection at Oldway School, namely the overcrowding and inadequate number of toilets and insufficient hand washing facilities that existed together with a large number of children in the 5 to 9 years age group who appeared to be susceptible to the disease. Although I cannot prove it scientifically I am sure that the rigid hygiene precautions, especially hand dipping in Benzalkonium Chloride solution played a great part in preventing the spread of infection in other schools, and in checking the further spread of infection at Oldway School.

I am grateful to the Headmaster and staff at Oldway Primary School and the staffs of other Paignton Schools for the excellent co-operation given to the Public Health Department during the outbreak, and also to the Director of the Public Health Laboratory at Exeter for his help and advice."

JOHN WILDMAN.

Infective Hepatitis

During 1967 the school health service co-operated in a trial of the efficacy of Gamma Globulin in preventing infective hepatitis, at the request of the Public Health Laboratory Service.

This involved giving injections of gamma globulin, with the consent of the parents, to half of the children in contact with the disease.

During the year outbreaks of the disease in 22 schools were investigated, and in many cases the full trial was undertaken. Results have been reported to the Public Health Laboratory Service.

IMPROVEMENTS TO SCHOOL PREMISES

Lastly, but by no means least, is appended a list of improvements to school premises during the year. Devon is a rural area with many small schools. The condition of lavatories in many primary schools remains unsatisfactory in spite of valiant efforts by caretakers; and seems worthy of a higher priority for improvement than given to it at present.

Improvements to Sanitary Accommodation, etc., Minor Improvements

Primary Schools	County Area
<i>School</i>	<i>Improvements</i>
Ashwater C.P.	Electric heating to 2 cloakrooms. Additional lighting points.
Bishopsteignton C.A.	Lavatory for infants.
Bovey Tracey C.P.	Renewal of urinal.
Bradford C.P.	Fluorescent lighting throughout school. Sink units in main classroom and infants' room. Additional heating in infants' room.
Bradninch C.P.	Additional fan heaters.
Broadclyst C.P.	New lavatory block.
Buckfastleigh C.P.	Covered way to toilets.
Cheriton Bishop C.P.	Extractor fan in boys' toilets.
Christow C.P.	Fluorescent lighting.
Clyst St. Mary C.P.	Drinking fountain. Additional power points.
Cullompton C.P.	Additional power points.
Dalwood C.P.	Renew sanitary fittings and roof in toilets.
Halberton C.P.	Fluorescent lighting.
Hatherleigh C.P.	Frost-proof toilets. Electric heaters for M.I. room and corridor.
Hemyock C.P.	Convector heater.
Hennock C.P.	Electric fan heaters.
Honiton C.P.	Power sockets in all classrooms.
Ide C.P.	Electric fan heater for large classroom.
Ipplepen C.P.	Replace concrete floor with vinyl tiles.
Membury C.P.	Washbasin with electric heater.
Newton Abbot Decoy C.P.	Renew urinal and W.C.'s. Fluorescent lighting in classrooms.
Newton Abbot Highweek C.P.	New lavatory block.
Okehampton C.P.	Separate toilet/cloakroom accommodation for female staff.

School

Ottery St. Mary Infants
Seaton C.P.

Shaldon C.P.
Spreyton C.P.
Tiverton Bolham C.P.
Widcombe-in-the-Moor C.P.
Yeoford C.P.

Voluntary Primary

Branscombe C. of E.
Bridgerule C. of E.
Buckfastleigh R.C.
Chudleigh C. of E.
Diptford Parochial
Exbourne C. of E.
Holcombe Rogus (Hebber's)
Ideford C. of E.
Kingkerswell C. of E.
Poltimore and Huxham
Stockland
Thorverton C. of E.
Totnes C. of E.
Uplozman

Grammar Schools

Okehampton

Secondary Schools

Bampton
Honiton C. Sec.

Special Schools

Totnes Crichel Hostel

Primary Schools

Lee Moor C.P.

Milton Abbot C.P.

Voluntary Primary

Charleton C. of E.

Primary Schools

Brixham Drew St.
Brixham Furzesham Hill
Kingswear C.P.
Stoke-in-Teignhead C.P.
Sherwell Valley Junior

Grammar Schools

Torquay Boys'

Primary Schools

Barnstaple Cyprus Terrace
Monkleigh C.P.

Improvements

Renew urinal.
Replace stoves in hall with electric night-store heaters.
Enclose toilets.
Frost-proof toilets.
Fluorescent lighting.
3 additional washbasins.
Drinking fountain in Infants' cloakroom.

Electric fan heaters.
Electric fan heater in cloakroom.
Sink in Infants' cloakroom.
Sink and drainer in classroom.
Improvements to lavatories.
Hot water to basins.
Hot water supply to sink.
Electric fires in Infants room.
Electric heating in corridor and cloakrooms.
Provide staff toilet and improve boys' toilet.
Enclose toilets.
Staffroom and storeroom.
Hot water to boys' and girls' washbasins.
Enclose boys' toilets.

County Area

Hot water to wash basins in all changing rooms.

Renew urinal.
New lavatory block.

Improvements to outside toilets.

South-West Area

Drinking fountain.
Indoor lavatory for staff.
Electric lighting and heating to cloakroom.
Fluorescent lighting.

Provide 2 drinking fountains.

Torbay Area

Electric heaters in each temporary equipment.
Sink in junior boys' and girls' toilets.
Covered way to lavatories.
Enclose toilets.
Sink in girls' toilets.

2 drinking fountains.

North Devon

Staff toilet.
Male staff toilet.

<i>School</i>	<i>Improvements</i>
North Molton C.P.	Drinking fountain.
South Molton C.P.	Additional boys' toilet.
Winkleigh C.P.	Frost-proof toilets.
Voluntary Primary	
Barnstaple Holy Trinity	Improvements to lavatories.
Paracombe Parochial	Fluorescent lighting to 2 classrooms.

MENTALLY HANDICAPPED CHILDREN

We now have over 200 children attending training centres in the county.

Ascertainment

Many children are admitted to junior training centres on an informal basis, and ascertainment procedure undertaken only after a period of observation. Educational psychologists visit the centres regularly and the review of children is undertaken to see whether a child can profit from education in school. It is imperative that the interchange of children between school and centre be facilitated.

During 1967 several children were re-ascertained as educationally subnormal and left the centres to attend special schools.

JUNIOR TRAINING CENTRES

There are four of these in the county:

			Day Pupil Places	Residential Places
Abbeyfield, Abcey Road, Barnstaple	..	..	60	*28
Mayfield, Torquay Road, Paignton	..	..	48	—
Oaklands Park, Dawlish	..	..	48	43
Downham, Horn Lane, Plymstock	..	..	†60	*22

* Weekly hostels.

† Includes children from Plymouth City Council.

From this it can be seen the provision is made for 215 places, 43 of which are fully residential and 52 for weekly boarders.

In April 1967, as a result of boundary changes, Plympton and Plymstock became part of Plymouth City. However, as the majority of the children at Downham attended from the new county area, it was agreed that the centre and hostel should continue to be administered by the County Health Authority. This arrangement is working smoothly.

Staff

The staff/pupil ratio remains at 1 : 12 children.

The admission of children of 5 or under to the Centres means that many are not yet toilet trained and during the year an infant helper has been appointed at each centre to free the teacher from toilet training the children.

The policy of sending any unqualified staff for full-time training continues. Untrained teaching staff are recruited only on the understanding that they are prepared to take a course and we hope that ultimately all staff will be trained.

We would like to have at least one male teacher at each centre but recruitment of suitable staff is difficult. However, at two centres there is a male member of staff.

The work of the infant helpers has been invaluable and during the year two of our infant helpers were promoted to the teaching staff.

Accommodation

Extensions at Downham and Mayfield were completed during 1967 and have been much appreciated by staff and pupils.

Curriculum

Great advances are being made in the understanding of the learning processes and abilities of the mentally handicapped child. The staff of the four training centres are all keen to try any method which will help the children, in this rapidly developing field of child care.

The children are being taught (albeit slowly) along the lines of the nursery and infant schools' curriculum—each one encouraged to use his abilities to the limit; to experiment and to create.

Some older children after completing a pre-reading course, are able to read a little. All children are trained to recognise words important to daily living, e.g. "Danger", "Bus-Stop", "Ladies", "Gentlemen".

Social training is given emphasis, being recognised as the most important factor in community acceptance. Many children are socially almost as well developed as the normal child, in spite of their low intellectual development. Children are encouraged to widen their general knowledge and interests, and to become as independent and self-assured as possible.

We are becoming increasingly aware of the need for more specialised physical education to improve balance, co-ordination and self confidence.

Health

The general health of children remains excellent apart from the usual childish ailments. Daily attending children have up to an hour's journey twice a day to attend the centre—which makes a long day for them—yet they thrive.

Many children at the training centres have other handicaps besides mental subnormality, but are quickly accepted and absorbed into the community. It is rare for a child not to "settle" at the centres or the hostels. If he comes from a home where he is loved and accepted for what he is, there are few difficulties.

School Medical officers visit the centres regularly for medical inspections and take a great interest in the children and the centres.

Parent Teacher Association

All the centres have an active P.T.A. and a wide circle of friends, who contribute most generously to provide amenities for the children which are outside the scope of a local authority budget.

Special Care Unit

This Unit started to take a few severely physically and mentally handicapped children in May and was officially opened by Lady Bennett, wife of Sir Frederick Bennett, M.P. for Torquay, in November 1967. We were delighted that so many parents were able to attend this function. The Unit has day places for 12 children, though not all children on the roll are able to attend every day. There is a staff of three, headed by a trained nursery nurse.

Even in the short time the Unit has been open progress has been noticed in the children.

Escorts

Escorts were provided in about half of the cars carrying children to the junior training centres, the head teachers deciding on their knowledge of the children which must be escorted. The question of whether all children should be escorted is under review.

BASILDON CHILDREN'S HOME, EXMOUTH

This is a local health authority children's home for convalescent, socially and emotionally deprived children. As a result of staff illness the Home had to be closed for two weeks in the summer.

There is no doubt of the value of a holiday at Basildon to a child, but in 1967 there were less applications for admission, and at the end of the year the future of the Home was in doubt.

SPECIAL FAMILIES

The key worker with these families is of course the health visitor, but *par excellence* this is the field in which she needs to have a good working relationship with her colleagues. The bulk of co-ordinating committee work is decentralised to the field officers, and we have been more than justified by the excellent way in which they have handled matters. Whoever convenes the local meeting takes the chair, and is responsible for submitting reports to central office. Members of other services, for example Probation, N.S.P.C.C., may be invited as appropriate.

Any health visitor who wishes to have further guidance about a family can contact Miss McGilvray, a group adviser with special responsibility for these families throughout the county; she goes out to the health visitor and usually visits the family also. The senior medical officer is kept informed by Miss McGilvray and, if any officer feels a co-ordinating meeting should take place at central level, request is made to a member of the education department, who convenes these, and he is informed of the circumstances.

The following figures give the measure of the work. The "others" in the first group are those on whom a close watch is kept but who are, for the moment, keeping their heads above water; in the second, potential, group the "current" ones are those recently reported as possible breakdowns should some outside factor upset the equilibrium, and on whom we therefore keep a watchful eye and try to reinforce weak points; the "others" are one place removed again, and least likely of all to break down, but as this service aims at prevention as well as alleviation, we ask for all such families to be reported.

Basildon, our convalescent home at Exmouth, has proved an effective means of preventing a family break-up, as well as providing the children with a chance to build up their low resistance.

SPECIAL FAMILIES 1967									
Current	..	..	..	..	..	..	..	..	129
Others	..	..	..	..	..	..	..	..	151
Total									280

POTENTIAL SPECIAL FAMILIES 1967

Current	..	..	..	..	..	..	..	..	127
Others	..	..	..	..	..	..	..	..	295
									<hr/>
Total									422
									<hr/>

CO-ORDINATING MEETINGS 1967

27

CHILDREN FROM SPECIAL FAMILIES IN BASILDON
1967 .. 16 families, 41 children

LIAISON WITH OTHER DEPARTMENTS

The senior medical officer for the child health section is the official liaison officer, but co-operation is close at all levels, and the development of the local co-ordinating meetings as described in the section on special families has made this even more effective.

In addition, Miss McGilvray attends the children's department case conference at Villa Languard once a month. This is a reception home and the conference occasion is most valuable both from the point of view of getting to know the child care staff who attend to report on progress in planning for children from their areas, and because many of the children are already known to the health department as members of a special family. The link is extremely important when a child is discharged from the home, as the health visitor can be alerted in the receiving area. Dr. Epstein is medical officer to Villa Languard and she gives expert advice on health matters both in the particular and in the broadest social sense of health education.

The children's officer keeps the health department up to date on children's department matters by sending us copies of relevant minutes, and in particular we are most grateful for the copies of the minutes of area children's officers' meetings.

Liaison with the welfare department is mainly at field level but Miss McGilvray and Miss Williams, deputy welfare officer, have developed an excellent understanding in relation to the care of problem families and also in the training of new staff who are given an insight into the work of the health department. This is extremely important because it is ignorance of one another's distinctive function which causes difficulties among the field workers, particularly when areas of responsibility overlap as much as they do between health and welfare departments.

The understanding and co-operation invariably offered by the administrative staff of the education department is very much appreciated. This team work is vital if the school health service is to run smoothly.

DAY NURSERIES AND CHILD MINDERS

<i>Nurseries</i>	1965	1966	1967
Number on register, 31st December	36	50	66
Permitted number of children at these nurseries	796	1,096	1,547
New registrations	17	17	24
Cancellations	6	3	3

Child Minders

Number on register, 31st December	..	..	40	67	58
Permitted number of children	..	..	370	605	533
New registrations	..	..	14	32	20
Cancellations	..	..	4	5	17

During 1967 the number of places for children in day nurseries and with child minders increased from 1,701 to 2,080. This was in spite of the loss to Plymouth in April of five day nurseries and twelve child minders as a result of the Plymouth boundary changes.

All but two of the new registrations were in order to form play-groups either in private homes or on hired premises such as village halls.

The majority of children who attend day nurseries or the homes of child minders do so because their parents realise the value of children mixing together where play facilities are good. The child of the working mother is the exception rather than the rule.

Supervision

Proposed applicants and premises are visited by a medical officer and also, in the case of day nurseries, by a fire officer. When the necessary standards of staffing and accommodation have been fulfilled registration is granted. Thereafter supervision is maintained by regular visits from a health visitor and visits by a medical officer when necessary.

Courses for playgroup staff

During 1967 the co-operation between the health and education departments and other organisations increased.

In February and March a course for West Devon playgroup staff consisting of seven evening sessions was organised jointly by the health and education departments. This dealt with various aspects of playgroup work. 90 playgroup staff from West Devon attended.

In the spring the Institute of Education of Exeter University agreed to run similar courses elsewhere in Devon, and during the summer term courses were put on by them in Exeter and Torquay. A course was started in Barnstaple in November 1967 and was completed in the New Year. Approximately 60 playgroup staff attended each of these courses.

A day's course was held at Dartington Hall on Saturday, 20th May. This was limited to 80 playgroup staff though twice this number would have liked to attend.

The infants and nursery advisor to the education department is prepared to advise any playgroup on the educational aspect of the work.

She started in 1967 to hold small meetings of playgroup leaders in local infant schools in certain parts of Devon. She hopes eventually to invite all playgroup leaders to such meetings.

The Pre-School Playgroups Association also held courses for playgroup staff in Devon.

These courses have helped to encourage interest in the work and the standard of playgroups is increasing steadily.

THE SCHOOL DENTAL SERVICE

Mr. F. H. Stewart, Chief Dental Officer from 1st January 1968, has completed the following report for 1967:

Staff

The untimely death in the middle of the year, of Mr. J. D. Sykes, Chief Dental Officer, overshadowed the whole School Dental Service in 1967. Mr. Sykes was a highly esteemed colleague who was fervently devoted to the furtherance of the County Dental Service and despite his ill health during his last year as Chief Dental Officer, he strove diligently and earnestly to improve the service. The results of his efforts are plainly seen and are highly appreciated by all members of the Dental Staff. His death is deeply regretted by all the staff in Devon and by many beyond the boundaries of this County, who respected his professional judgement, his sincere consideration for others and the quiet warmth of his engaging personality.

In the latter part of the year, Mr. G. J. Derbyshire assumed the role of Acting Chief Dental Officer and despite the obvious difficulties of taking this responsibility at short notice and without adequate prior knowledge of the administration of the Service, he quickly established himself as a willing, capable and well liked Deputy. The writer is particularly indebted to Mr. Derbyshire for his considerate handling of the Service in the latter part of the year. There can be no doubt of Mr. Derbyshire's ability to establish, co-ordinate and further improve the Dental Service of Torbay, from his appointment as Chief Dental Officer to that Authority in April 1968.

The two full-time vacancies which existed at the beginning of the year were filled by the appointment of Mr. A. R. Gammack to Barnstaple in April and of Miss V. E. Street to Honiton in June. Pending Mr. Gammack's appointment, Mr. J. Smith assisted in a part-time capacity in the early part of the year at Barnstaple Clinic. Miss Williams resigned her post of Dental Auxiliary at Torquay in April and the vacancy remained until September, when Mrs. Martin, who had been the first full-time Dental Auxiliary to be employed in Devon, returned to part-time duties.

Clinics and Equipment

Further progress was made in the year, with the opening of the dental suite at Ilfracombe Health Centre, which has already been highly appreciated by patients and staff alike. Fully equipped surgeries within purpose-built accommodation of this kind, allied to the use of a mobile clinic in the more distant parts of the area, offer ideal conditions for the comprehensive treatment cover of all eligible patients. It can be reported that plans are in hand for the establishment of similar dental suites at Cullompton and South Molton, Holsworthy and Sidmouth. Each clinic will greatly improve the Service in the area concerned.

Minor improvements were carried out in fixed clinics, notably at Tiverton, where a new dental unit was installed. Despite these improvements, however, much remains to be done before equipment facilities and accommodation at all fixed clinics can be considered to be completely satisfactory.

One mobile dental clinic was ordered within the year for delivery early in 1968 and this additional clinic will ease the difficulty of programming the existing fleet to meet the needs of the whole county. A large proportion of those schools visited in the past by a dental officer using portable equipment has, in recent years, been transferred to the growing list of schools where treatment is provided in the mobile dental clinic. This improvement in treatment facilities

made available to pupils in rural areas is possible only after site facilities have been installed for the mobile clinic at the schools concerned. Because of financial restrictions this is a gradual, but continuing process. Progress in this field must be maintained until the use of portable equipment is abandoned completely.

The difficulty in having clinic facilities available in Exeter to meet the demands of patients in the adjoining county area, reached its climax at the end of the year, when the use of the dental surgery at the Royal Devon & Exeter Hospital was withdrawn. Arrangements were made at the end of the year, through the courtesy of the Exeter City Authority, to make one of their surgeries available for use by County Dental Staff on Saturday mornings. This is a welcome solution to what would otherwise have been an extremely difficult problem.

Inspection and Treatment

New "areas" for Dental Officers were adopted early in January and with only minor variations effected in the course of the year, the areas are considered by the Staff to be satisfactory. The re-allocation of areas was planned to anticipate the boundary variations for the Plymouth and Torbay districts and at the same time to achieve a more equable distribution of schools and school population amongst various Dental Officers. On balance, the charges can be said to be successful on both counts.

In April, the boundary of Plymouth was extended to include the Plymstock and Plympton districts and one dental clinic with the Dental Officer based there, Cdr. F. A. Pearse was transferred to the Plymouth Authority. The total school population eligible for treatment within the County area was reduced by 4,600 approximately, who now have treatment within the Plymouth School Dental Service. This change has produced the one serious anomaly in the revision of Dental Officer's areas within the County. Clinics at Tavistock are not served adequately enough by public transport to permit patients in Ivybridge, Yealmpton, Wembury and surrounding districts to travel, regularly for routine continuation, emergency and orthodontic treatment. Occasional dental sessions at the health centre planned for Ivybridge should resolve this problem.

Most Dental Officers complete a circuit of their area within the year and a few can re-inspect some primary schools in the same year. No Service can be considered to be comprehensive until six monthly "checks" followed by treatment where necessary becomes the routine for each consenting patient. 1,247 school children received a second or subsequent course of treatment in 1967 and an increase on this figure should be expected in future years.

The total volume of treatment in 1967 as shown in the following summary is less under most headings, than for the previous year. This is due to the loss of Cdr. Pearse from the County Staff on his transfer to Plymouth and to illness, which together amounted to more than the equivalent of one full-time dental officer.

Those cases which required Specialist treatment in hospital, were referred to Mr. P. A. Bramley and Mr. P. H. D. Lewars, the Consultant Oral Surgeons in Plymouth and Exeter. We are indebted to both for their willing assistance in providing treatment for patients who are referred.

ATTENDANCES AND TREATMENT

	Total
First Visit	13739
Subsequent Visits	20419
Total Visits	34158
Additional courses of treatment commenced	1247
Fillings in permanent teeth	22083
Fillings in deciduous teeth	10253
Permanent teeth filled	18829
Deciduous teeth filled	9349
Permanent teeth extracted	1609
Deciduous teeth extracted	5625
General anaesthetics	1445
Emergencies—see note (c) attached	813

Number of Pupils X-rayed	941
Prophylaxis	4302
Teeth otherwise conserved	2226
Number of teeth root filled	30
Inlays	10
Crowns	20
Courses of treatment completed	12957

ORTHODONTICS

Cases remaining from previous year	380
New cases commenced during year	170
Cases completed during year	113
Cases discontinued during year	14
No. of removable appliances fitted	388
No. of fixed appliances fitted	20
Pupils referred to Hospital Consultant	137

Orthodontics

Further appreciation of Mr. Barnett's advice and treatment for orthodontic patients is shown in annual reports from Dental Officers. Mr. Barnett encompasses the length and breadth of the County, with his regular sessions in each area. Despite this wide field of operation, the arduous travelling and transport of necessary equipment his coverage of the County is almost complete. Waiting lists for treatment still exist in a few clinics, but these are gradually being reduced. Mr. Maurice Burley, the Consultant Orthodontist at Exeter discusses the more complex orthodontic cases with Mr. Barnett, at a regular monthly session. Our thanks are due to Mr. Burley for maintaining this important link between the Hospital Service and the Local Authority.

Refresher Courses

Mr. Shipley attended a course on "Dental Treatment for the Handicapped Child" and both Mr. Gibbs and Mr. Warren attended the International Sym-

PROSTNETICS

	Total
Pupils supplied with F.U. or F.L. (first time)	2
Pupils supplied with other dentures (first time)	39
Number of dentures supplied	52

ANAESTHETICS

General Anaesthetics administered by Dental Officers	1095
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INSPECTIONS

(a) First inspection at school. Number of Pupils	52817
(b) First inspection at clinic. Number of pupils	4350
Number of (a)/Æ(b) found to require treatment	28973
Number of (a)/Æ(b) offered treatment	22156
(c) Pupils re-inspected at school or clinic	1371
Number of (c) found to require treatment	969

SESSIONS

Sessions devoted to treatment	6821
Sessions devoted to inspection	691
Sessions devoted to Dental Health Education	475

posium on Child Dental Health. This latter "refresher course" was the first of its kind to be held in this country and Mr. Gibbs pays tribute to "the speakers covering rather a wider field than the normal refresher course".

Both these courses were of short duration and while they fill the need to "refresh" on particular aspects of children's dentistry lack of time inevitably curtails the content. It is to be hoped that longer courses which last at least one week and which come nearer to embracing the whole orbit of the treatment of children will be more readily available in future.

Dental Health Education

Miss Turnage continued her programme of visiting each primary school in the county and by the end of the year had almost completed a schedule of visits which had lasted two and a half years. It is now possible to commence a series of second visits to primary schools, where the content and material used will be varied to maintain the interest of children in oral hygiene. Despite Miss Turnage's enthusiasm and great personal involvement in her work, she continually faces the inevitable prospect of travelling time reducing her potential effectiveness. A second tour of the primary schools is estimated to take eighteen to twenty months. This interval between visits is far from ideal and can only be improved by the employment of additional staff. We are indebted to Miss Turnage for her untiring efforts in taking dental health education to a widely scattered but interested and appreciative primary school population.

Fluoridation

Over the past five years the Minister of Health, with the full weight of evidence to support fluoridation behind him, has encouraged Local Authorities to implement the fluoridation of public water supplies. In 1963 the Health Committee supported the Minister's view in a recommendation to the County Council, but later that same year the County Council deferred its decision pending the judgement of the Watford Court case. This legal action had been instituted in an effort to restrain Watford Corporation from adding fluoride to water supplies, but was subsequently withdrawn. In response to the Ministry Circular of August 1965, the Health Committee in December reiterated its view that fluoridation should proceed. In January 1966, the County Council rejected this recommendation.

The evidence supporting the case for fluoridation has been accepted by informed medical and dental opinion throughout this country. It is regrettable that we must now await the inevitably apparent evidence from more areas where fluoridation will be introduced before the voices of those who oppose this proven public health measure can be stilled. Public opinion will one day be so conversant with the benefits of fluoridation, through the improved dental health of children reared in areas of fluoridation being manifest to all, that fluoridation will not only be accepted but will be demanded by the general public. The results of the fluoridation studies in the United Kingdom were published in 1962 and added to the testimony of the effectiveness of fluoridation from studies carried out in other parts of the world. Five years have elapsed since 1962 and a further delay in the benefits of fluoridation being made available to Devon's children and future adults appears inevitable. It is to be hoped that this delay will be short.

Finally, I would like to couple my sincere thanks with those of the County Dental Staff to the Teaching Staff of the Authority for their excellent co-operation and valued assistance throughout the year. Our thanks are due also

to the Dental, Medical and Clerical Staff, both in the field and at County Hall and if I single out Mr. J. H. Hirst for special mention, it is only because Dental Officers have been unanimous in their appreciation of his patient and considerate attention to their needs during what was, administratively, a difficult year.

JUNIOR TRAINING CENTRES

Dental Inspection and Treatment

Children in all the centres were inspected and the amount of treatment provided is as follows:

Number inspected	..	..	164	Fillings	..	..	..	106
Number requiring treatment	..		89	Extractions	..	..	..	49
Number treated	..	..	69	Prophylaxis	..	..	..	35
Attendances for treatment	..		107	General Anaesthetics		..		24

During the year, two children were referred for in-patient treatment in hospital.

PART VIII
PARTICULARS OF CLINICS, ETC.
as at 1-7-68

**THIS LIST IS LIABLE TO ALTERATION
WITHOUT NOTICE, ACCORDING TO
THE DEMANDS OF THE SERVICE.**

		Telephone Number	Child Welfare Centre	Ante-Natal Clinic	Cytology Clinic	Chiropody Clinic	Audiology Clinic	Speech Therapy Clinic	Ophthalmic Clinic	Dental /and Authodontic Clinic	Child Guidance Clinic	Other Unspecified Clinics
APPLEDORE			*									*
Hall, Newquay Street												
ASHBURTON			*	*	*	*		*	*	*		
Health Centre												
AXMINSTER			*	*								
Methodist Church Hall						*		*		*		
District Hospital												
Secondary School												
BAMPTON						*						
Nurses Bungalow												
BARNSTAPLE	Clinic	5137	*	*	*	*	*	*	*	*	*	*
Clinic, 19b Alexandra Road	CGC.	3048										
BERE ALSTON					*	*						
3 Station Road				*								
Church Hall												
BIDEFORD			*	*	*		*		*	*		
Parish Church Institute												
Clinic, Coronation Road		3163	*			*		*	*	*		
Community Centre, East the Water												
BOVEY TRACEY			*	*	*	*		*	*	*		
Health Centre, Abbey Road		2666										
BOW						*						
Nurses Home, Moor View												
BRADWORTHY						*						
Memorial Hall												
BRATTON CLOVELLY						*						
Parish Hall												
BRAUNTON			*	*		*						
Parish Hall												
BROADCLYST			*	*								
Victory Hall								*				
County Secondary School												
BUCKFASTLEIGH			*	*	*	*			*	*		
Health Centre, Bossall Road		2171										
BUDLEIGH SALTERTON			*	*	*	*		*	*	*	*	*
Health Centre, 1 The Lawn		2213										
CHAGFORD			*			*						
Jubilee Hall												
CHERITON BISHOP						*						
Village Hall												
CHUDLEIGH			*			*						
St. John Ambulance Hall												
British Legion Hall												
CHULMLEIGH				*		*						
Wallingbrook Village Hall												
Over 60's Club												
CLYST ST. MARY			*									
Village Hall												
COLYTON			*	*	*	*		*	*	*		*
Health Centre, Off South Street		728										
COMBE MARTIN			*	*	*	*		*	*	*		*
Health Centre		2606										
CREDITON			*	*	*			*	*	*		
Clinic, Newcombes		2649				*						
Bowden Hill												
CULLOMPTON			*	*		*				*		
Parish Rooms												
DARTMOUTH			*	*	*	*			*			
Clinic, Mayors Avenue		2845	*									
Baptist Church Hall												
DAWLISH			*	*		*		*	*			
Clinic, The Knowles		3254										
EXETER								*			*	
Clinic, 97 Heavitree Road		76348			*							
Alice Vlicland Centre, Bull Meadow Rd.												
EXMINSTER			*			*						
Victory Hall												
EXMOUTH			*	*	*	*	*	*	*	*		*
Clinic, 89 Withycombe Road		2610										
FREMINGTON			*									
Parish Hall						*						
GEORGEHAM												
Village Hall												

	Telephone Number	Child Welfare Centre	Ante-Natal Clinic	Cytology Clinic	Chiropody Clinic	Audiology Clinic	Speech Therapy Clinic	Ophthalmic Clinic	Dental Clinic	Child Guidance Clinic	Other Unspecified Clinics
HARTLAND Women's Institute Hall		*	*		*						
HATHERLEIGH 26 South Street					*						
HARBERTON Village Hall			*								
HOLSWORTHY Town Hall		*	*	*	*			*			
HONITON Clinic, Northcote Lane	2252	*	*	*	*		*	*	*		*
HORRABRIDGE Methodist Church Rooms		*									
IDE Memorial Hall					*						
ILFRACOMBE Health Centre, Marlborough Road	3521	*	*	*	*	*	*	*	*		*
INSTOW 4 Bath Terrace					*						
IPPLEPEN Health Centre, Biltor Road	621	*	*	*	*			*	*		*
IVYBRIDGE Methodist Church School Hall		*	*		*						
KINGSBRIDGE Clinic, Fore Street	2606	*	*	*	*		*	*	*		
KINGSKERSWELL Public Hall		*			*						
KINGSTEIGNTON Health Centre, Whiteway Drive	3861	*	*	*	*			*	*		*
KINGSNYMPTON Church Hall					*						
LEE MOOR Memorial Hall		*									
LEWDOWN The Victory Hall					*						
LIFTON Methodist Church Rooms		*									
LITTLEHAM Church Hall		*									
LYNFORD Nicholas Hall					*						
LYNTON Health Centre, Burvill Road	3226	*	*	*	*		*	*	*		*
MARLDON Old School		*	*		*						
MODBURY Memorial Hall		*									
MORETONHAMPSTEAD Methodist Hall		*			*						
NEWTON ABBOT Clinic, 21 Courtenay Park	2445	*	*	*	*		*	*	*		
NEWTON POPPLEFORD Methodist School Room					*						
NORTHAM Church Hall		*			*						
NOSS MAYO Village Hall					*						
OKEHAMPTON Health Centre, Memorial Hospital Grnds	2231	*	*	*	*		*	*	*		*
OTTERY ST. MARY Health Centre, Sandhill Street	2288	*	*	*	*		*	*	*		*
PRINCETOWN Ladies' Club Hall		*	*		*						
ROBOROUGH Recreation Hall		*									
ST. GILES-ON-THE-HEATH Coronation Hall					*						
SALCOMBE Methodist Hall		*	*								
Baptist Hall					*						
SEATON Health Centre, Harepath Road	877	*	*	*	*			*	*		*
SHEBBEAR Church Rooms					*						

	Telephone Number	Child Welfare Centre	Ante-Natal Clinic	Cytology Clinic	Chiropody Clinic	Audiology Clinic	Speech Therapy Clinic	Ophthalmic Clinic	Dental Clinic	Child Guidance Clinic	Other Unspecified Clinics
SIDFORD		*									
Reading Room		*									
SIDMOUTH		*	*								
Congregational Church Hall					*						
St. John Hall											
Secondary Modern School									*		
SILVERTON											
30A Fore Street					*						
SOUTH BRENT		*									
Church Hall											
SOUTH MOLTON		*	*	*	*	*	*	*	*		*
Clinic, 99 East Street	2352										
STICKLEPATH		*									
Parish Hall											
STOKE CANON		*									
Jubilee Hall											
STOKE GABRIEL		*									
Church Hall											
STOKENHAM					*						
Parish Hall											
TAVISTOCK		*	*	*	*	*		*	*		*
Clinic, Crowndale Road	2617										
Westbridge											
TEDBURN ST. MARY					*						
Pathfinder Caravans					*						
TEIGNMOUTH		*			*			*			
St. James Room			*								
Gospel Hall					*						
2 Den Crescent											
THURLESTONE					*						
Parish Hall											
TIVERTON		*	*	*	*	*	*	*	*		*
Clinic, St. Andrews Street	3341										
TORRINGTON		*	*	*	*		*	*	*		*
Health Centre, New Road	2282										
TOTNES					*			*	*		
Rosabelle, Plymouth Road	2335	*	*					*	*		
Borough Park Hut	2078										
UFFCULME					*						
6 Commercial Road											
WEMBURY		*									
Village Hall											
WESTWARD HO°					*						
Chalet Private Home											
WINKLEIGH					*						
Nurse's Bubgalow											
WITHERIDGE					*						
Parish Hall											
WOODBURY					*						
Village Hall											
WOOLACOMBE		*			*						
Methodist Hall											
YEALMPTON		*	*		*						
Women's Institute Hall											
Chapel Rooms											
YELVERTON					*						
Church Hall			*								
Memorial Pavilion											

